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THE PUBLIC HEALTH NURSE AND AFTERCARE

BY J. CUMMING, M.D., N. BIGELOW, M.D., A. L. HALPERN, M.D., C. CALTHROP, B.A., AND M. CRILL, R.N.*

In September 1961, a group of agencies serving Onondaga County in New York State started a program to improve the follow-up care of mentally ill patients after they left the major treatment center available to the county, Marcy State Hospital.** The program was organized around the three public health nursing agencies in the county. Before describing this program, the authors would like to comment on an increasing use of the public health nurse as an agent in aftercare and to describe some of the events which led to the Onondaga County program.

A number of states are now making use of public health nurses in aftercare. The sound reasons for using them in aftercare programs† have been apparent for some time in rural areas where population is thinly spread and where it is physically impossible for a central agency to maintain contact with former patients. During the fall of 1961 Marcy State Hospital provided a week-long course for Warren County public health nurses and there has since been a continuing informal relationship with the hospital social service department. Recently, there has been a rapid increase in such programs in more urban locations. The forces behind

*Many others as well as the authors have worked to bring this program into being. Dr. Graves, clinical director; Dr. R. Leja, clinic psychiatrist; Miss M. Purcell, supervisor of psychiatric social work; Mrs. C. Abrahamer, former, and Mrs. H. Helmle, present, chief of nursing services and training—all of Marcy State Hospital—worked vigorously to set up the program. The directors of the three participating public health nursing agencies—Miss Alyce Rooney, director of the Bureau of Nursing, Syracuse Health Department; Miss Irene McCarthy, director of Onondaga County Public Health Nursing Service; and Mrs. Nora Rothschild, director of the Visiting Nurse Association of Syracuse—spent a great deal of time on the details of the program. Stewart F. Raleigh, Jr., chairman of the Mental Health Committee of the United Community Chest and Council of Onondaga County has guided the advisory board since its inception and has taken over many important administrative tasks.

**In December 1961, the project received grants from the Rosamond Gifford Charitable Corporation and from the Division of Community Services of the New York State Department of Mental Hygiene to enable it to employ a project co-ordinator and to supply her with secretarial help.

†Some of the better known examples are the programs of the Public Health Department of the State of Georgia, the Visiting Nurse Association in Hartford, Conn., and the Monmouth County Project of Redbank, N. J.

this expansion are probably generated by changes in the social service departments of hospitals, changes in public health nursing services, and changes in the functioning of the state hospital.

Social Service Department Changes in State Hospitals

Social workers have traditionally been the key people in the aftercare of the mentally ill, even when they were in extremely short supply, and indeed, completely absent in some areas. For some time there was a hope that new graduates from the schools would repair this deficiency in a reasonable time. Now, it is realized that nationwide this is a dubious hope. As the schools already have difficulty in recruiting all the students they could train, it does not seem likely that the number of graduates will increase markedly. At the same time, the variety of jobs which are being filled by social workers is increasing, and agencies that have heretofore used social workers with no formal academic training have begun to provide in their budgets for graduates from schools of social work. All of this means that state hospitals are facing more competition in recruiting social workers. It becomes increasingly obvious that these hospitals will have to use their trained workers for the specialized jobs of supervision, teaching, consultation, skilled casework and trouble-shooting. Even so, the expansion of the social worker's job in the hospital itself is going to make for increasing calls on her talents and time.*

Changes in Public Health Nursing Agencies

In the last two decades a number of forces have operated to change the role of the public health nurse. The virtual elimination of communicable diseases has allowed her to consider new fields, and stubborn problems of chronic illness and mental illness have suggested themselves to her. At the same time, the increasing emphasis on the influence of social and psychological factors in physical illness has meant that schools of public health nursing have been teaching more about emotional problems. The public health nurse is beginning to see herself and be seen by others as a resource for use in the community care of the mentally ill.

*For a discussion of the availability of skilled mental health workers in the future, see Albee, George W.: Mental Health Manpower Trends. Basic Books. New York. 1959.

Changes in the State Hospital

For reasons largely associated with the development of the newer drugs for the treatment of mental illness, the populations of state hospitals have been decreasing for the past six years. This change has come about because the hospitals are now discharging nearly all of the young and middle-aged patients who are admitted.* Formerly about one-third of this group might have remained in the hospital for long periods, some of them for the rest of their lives. It seems reasonable to assume that the discharges in excess of the previous ratio are likely to be occupationally and interpersonally inadequate persons. The proportion of the released group that returns to hospital remains constant, which argues that the hospital has not relaxed its criteria for release.** Nevertheless, the total discharged group continues to grow rapidly and the number of social problems within this group is probably increasing. All this argues for the necessity of more and perhaps broader aftercare services.

Background Planning

Onondaga County is perhaps better off than many places as far as aftercare is concerned. Marcy State Hospital, to which county patients are sent, operates an aftercare clinic for one afternoon and evening each week in Syracuse, the county's major city. It also maintains a staff of four (two and later three in 1959) social workers, who are based in the community, rather than in the hospital 50 miles away, and who devote their major time to the aftercare of upwards of 300 released patients. Nevertheless, a preliminary survey in 1959, showed that many patients had either given up or changed their medication without the advice of the aftercare clinic and that they had other unresolved psychiatric problems. Six months after leaving the hospital, half of those who wanted to work (whatever their capacity) were still unem-

*See Brill, H., and Patton, R.: Clinical-statistical analyses of population changes in New York State mental hospitals since introduction of psychotropic drugs. Paper read at annual meeting of the American Psychiatric Association, Chicago, May 10, 1961.

**This is an opinion expressed by the senior author only. It has been pointed that the same findings could be accounted for on other grounds. For instance, hospitals might have relaxed their discharge standards somewhat; and this could have been compensated for by an increased use of drugs among discharged patients and by a more accepting social climate in the community. Such an argument, if true, only underlines the need for the augmented aftercare services which are being developed.

ployed. Others complained of loneliness and inability to re-establish satisfactory social ties. It is conceded that this might well have been an expression of the basic personality.

Marcy State Hospital was concerned about providing a better chance for readjustment for its patients and was willing to join forces with the public health nursing agencies in an experiment in aftercare. The three nursing agencies in the county saw this, not only as an opportunity to give more services, but also as a source of training and consultation in the care of a special type of patient. Further, they believed that their over-all effectiveness might be increased while they prepared to provide this specialized service, because many of the patients already in their case loads seemed to have problems similar to those of the newly released mental patient.

Organization of Program

Once the nursing agencies and the state hospital had agreed in principle, a plan for administering the project was developed. The Mental Health Research Unit, a branch of the Department of Mental Hygiene of the State of New York, had been active in developing the project, but it was felt that administrative authority should rest with a permanent local agency that would take a continuing interest in the service aspects. When the mental health committee of the United Community Chest and Council agreed to act as a sponsoring agent, it was felt that the project had sent down roots into the community. The governing body of the project became a committee composed of representatives of the participating organizations and other groups in the community which might have special interest in the project.*

The first concern of the committee was a training program. It was decided that two types of training were essential: an extensive program, to increase the skill and knowledge of the public health nursing supervisors and a less intensive but longer course, designed to meet the specific needs of the staff nurses.

*The organizations included in the committee are United Community Chest and Council of Onondaga County; School of Social Work, Syracuse University; Onondaga County Medical Society; Department of Psychiatry, Upstate Medical Center; Onondaga County Mental Health Board; Social Service Department, St. Joseph Hospital; Public Health Nursing Division, New York State Health Department; Syracuse University School of Nursing; and the School of Public Health Nursing of the Upstate Medical Center.

Training of Supervisors

There are 11 supervisors in the three public health nursing agencies in Onondaga County. Most of them have been in the agencies for a number of years, and many had had no period of psychiatric affiliation. Four of these supervisors were assigned to the first intensive training course.* It lasted 12 weeks, with the first three working days of each week spent at Marcy State Hospital and the last two in Syracuse.

As in most of the institutions in the New York State hospital system, Marcy conducts a 12-week affiliation in psychiatric nursing for several schools of nursing. The organizers decided to use this course—which is designed to give student nurses an understanding of mental illness and ways of nursing the mentally ill patient—as the core of the supervisors' training. The lecture program was arranged for these affiliated students, so that all didactic material was presented during the first three days of each week. This program was enriched and modified at the hospital to meet the needs of the public health nursing supervisors. Further, the training in the community was designed to provide a link between what was learned in the hospital and what actually went on in the homes that the nurses visited. These aspects of the program will be taken up again later. First a brief outline will be given of the basic course.

Staff psychiatrists gave 40 hours of lectures covering all the psychiatric disease entities. They also conducted illustrative case conferences for a further five hours. In addition, there was a special two-hour lecture on the drugs used in mental illness, and another two-hour lecture on research. A two-and-one-half hour lecture on hospital policy, including legal aspects of admission and release, which, it had been felt might be superfluous for these experienced nurses, proved one of the most popular features because of its great practical value to them.

Lectures, conferences, and panels, conducted by the nursing instructors of the Marcy State Hospital School of Nursing, totalled 41 hours. These explained the nursing problems associated with each illness that the psychiatrists had discussed.

Presentation and discussion of psychiatric films occupied 11 hours. Thirteen hours were devoted to psychiatric social workers'

*Only one supervisor was replaced during the training period, which gives some idea of the magnitude of the agencies' contribution to the program.

lectures and conferences. Lectures by members of other disciplines, such as the hospital chaplains and ancillary hospital personnel totalled six hours. A total of 46 hours was spent on the wards, observing special therapies, and talking with patients under the guidance of psychiatric nursing supervisors. Ten hours were spent in sessions at Crane Hill School, Marcy State Hospital's residential treatment unit for children, and the supervisors spent a day at Rome State School for the mentally retarded.

This, in essence, was the program for affiliate students. In addition to this, however, it was felt that the mature nurses could benefit from more observation of the actual operation of the hospital. With this in mind, it was arranged for them to spend approximately 30 hours observing diagnostic and release conferences. In addition, the chief of nursing services and training at Marcy set up a special series of seminars under the direction of a psychiatric nursing instructor. This small group undertook an informal and vigorous search for answers to problems that they had come upon during their day-to-day activity. Discussion among themselves was easy, since they had accommodations at the hospital, and remained there for three days of each week. This also allowed special opportunities for informal discussion with social workers, psychiatric nurses and other members of the hospital personnel. Being at the hospital in the evening permitted them to observe and participate informally in many of the hospital's activities.

Course in Syracuse

The information gained in the hospital was general and had wide applicability. Nevertheless many of the skills the supervisors were learning were more appropriate to the large hospital than to the community. Such experienced nurses could undoubtedly have worked out community applications for much that they were being taught, but it was felt desirable to bridge the hospital-community gap with a training program conducted in the community.

This part of the course was under the direction of the staff of the Mental Health Research Unit. The instructors' group also included the director of Marcy's social service department; the senior psychiatric social worker from its aftercare clinic; a clinic psychiatrist; a social worker from the United Community Chest and Council; the mental health consultant from the School of

Public Health Nursing, Upstate Medical Center, State University of New York, and others.

Three or four recently released patients were assigned to each supervisor, who visited her patients once each week. Thirty-two hours were spent in this field work. Problems encountered and observations made in these visits were vigorously discussed in group sessions with a psychiatrist. These sessions, totalling 38 hours, served to integrate the formal, didactic course at Marcy with practical experience in the community. Each supervisor also received approximately an hour a week of individual supervision by a psychiatrist.

Eleven hours were devoted to special lectures by psychiatrists, psychologists and psychiatric social workers, who discussed such topics as "Stigma and its Resolution," "Factors in the Maintenance of Motivation," "Mental Illness in Cross-Cultural Perspective," and "Community Resources for Assisting Mental Patients." Conferences with social workers, totalling 11 hours, were concerned with many phases of the working relationships between the social worker and the public health nurse. Several hours were spent in direct observation of procedures at the aftercare clinic. The director of Marcy State Hospital conducted a special case conference on a multi-problem family with staff members from Marcy and the aftercare clinic participating. Visits were arranged to a community general hospital psychiatric unit and an out-patient psychiatric clinic. Finally, because it was felt that the supervisors should know something about programs different from one in which they were studying, they were invited to lectures by visiting consultants to the Mental Health Research Unit. Further, the group was given an opportunity to attend the mental health section of the Syracuse Regional Health Conference, which concerned itself with the topics of "Current Issues in Mental Health" and "The Community's Role in the Care of the Discharged Mental Patient."

Course for Staff Nurses

The training of staff nurses is planned to include a variety of experiences on the job, through direct referral of released patients to the public health nursing agencies. Discussion of the problems encountered will take place in weekly seminars over a period of several months, with a psychiatric consultant meeting groups of 10 to 12 staff nurses. During this period, it is anticipated

that staff nurses, four or five at a time, will spend a week in a specially designed course at Marcy State Hospital. Opportunities for attendance at staff meeting in appropriate agencies, such as mental health clinics and family agencies, will be arranged. The weekly meetings are to be focused on psychiatric symptomatology and nosology, and instruction about the indications, contraindications and side effects of the drugs used in the treatment of mental illness. These subjects are linked in discussion to the staff nurses' own cases and to their own problems with these cases. When possible, arrangements are to be made for participation in these case discussions by professional workers from other agencies concerned with the cases discussed.

Research

It is planned to measure the effects of the participation of the public health nurse in the aftercare of released mental patients, by determining both the rate of return to the hospital and the degree of adjustment in the community. The total of the released patients selected for referral to public health nursing service will be divided into two randomly selected groups; one will be referred for nursing visits, and the other, the control group, will not be referred.

Methods of referral, public health nursing techniques, special problems encountered, and evaluation of the total program will be discussed in future communications.

Discussion

It is still too soon to evaluate this program, but there are comments from the first group of supervisors about their general reactions to the course. It seems certain that they saw the hospital differently at the beginning of the course than they did at the end. One nurse said, "It has been exciting to see some of the newer techniques being tried in dealing with the mentally ill, such as remotivation classes, group psychotherapy and intensive activity." Another nurse pointed out that the hospital no longer seemed monolithic, and that when someone in a family said, "My daughter is in E Building," she would know something of the kind of patient and the conditions of her life in the hospital. The supervisors felt that they had added an informal working relationship

with the nurses and social workers in the hospital to their knowledge of the procedures and rules about hospitalization and release.

These nurses experienced a marked change in attitude toward patients during the three-month period. They seemed to have moved from the cliché that "patients are people just like the rest of us" to a firm conviction that patients are indeed people, but are people with special problems. They recognized, for example, that patients had difficulty in communicating and, as one nurse said, "We are all a little bit more comfortable during silences now." Their view of patients seemed more truly sympathetic, and yet they viewed them with more realism. Another nurse commented, "I've got a much better understanding of how to help patients and their families to work toward goals that are really attainable."

The authors think that other changes are already discernible. The closer relationship developing between the community and the state hospital as they worked together on this project has increased the acceptance of the hospital as a community institution. The authors can hope that this will diminish the fears and misconceptions usually connected with large hospitals. Within the hospital itself, two other similar programs are under consideration. Whether they were catalyzed by this program or whether all three owe their origin to similar social forces, one cannot tell at the moment.

This experiment should result in public health nurses bringing a new point of view to their work. Whether there will be success in the task of firmly establishing the framework within which they can use their new skills is still uncertain. Even if there is success, the final measurement must be whether or not this plan allows more mentally ill persons to make successful readjustments in the community.

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STUDIES ON FIGURE DRAWINGS*

A Review of the Literature (1949-1959)

BY LEONA W. JONES, Ph.D., AND CAROLINE B. THOMAS, M.D.

Introduction

Although psychologists have long been interested in the concept that the spontaneous drawings of ordinary folk reflect their personality characteristics, it was not until 1948 and 1949 that human figure drawings became a recognized testing procedure for personality assessment. In those years, Buck described the House-Tree-Person Test, and Machover published her book describing the Draw-A-Person Test.[1,2] Since that time, the Draw-A-Person Test, in particular, has been widely used by clinical psychologists as a projective technique, usually in conjunction with other projective tests such as the Rorschach Test or the Thematic Apperception Test.

Because it is relatively brief and simple to administer in contrast to other tests, the Draw-A-Person Test appears to have much in its favor as a psychological screening test. The fact that it has not been thus used depends largely on the lack of a systematic, reproducible scoring classification. For the most part, each investigator using figure drawings as a tool in a particular study has devised his own scale, with little reference to the work of others. Moreover, these scales are often limited to one or two aspects of the figure drawings, such as placement of the figure on the page, or sexual differentiation, without regard to the many other variables in constant use by clinical psychologists. Although the need for a practical classification is frequently cited, there is no established scoring system today which is at all comparable to the methods of Beck and of Klopfer for scoring Rorschach protocols.

The writers' interest in the problem stems from the long-term study of precursors of hypertension and/or coronary artery disease which has been in progress since 1946. Successive classes of Johns Hopkins medical students have been studied in regard to their genetic backgrounds and in regard to their own physiological, psychological, and metabolic characteristics. It is planned to follow these subjects over the years to determine which characteristics

*This study, from the Johns Hopkins University School of Medicine, was supported by a grant from the Tobacco Industry Research Committee.

are associated with the early onset of the disorders in question. To the writers' knowledge, this is the first projective study of hypertension and coronary disease in which systematic observations have been made of the subjects' psychological make-ups. Although a certain amount has been written about the personality of patients with hypertension or with coronary disease, the psychological traits of the prehypertensive or the precoronary individual are at present for the most part conjectures based on fragmentary or uncontrolled retrospective information. Accordingly, it was decided to make major use of projective techniques rather than to rely on nonprojective tests which might not include the items that would best reflect the prehypertensive or precoronary personality image. The Rorschach Test has been used since the study began. Figure drawings were introduced in 1951; a total of 779 students in the classes of 1952 through 1963 have taken the Draw-A-Person Test. Because of the availability of data of other kinds on the same healthy subjects for comparison and evaluation, this material provides a unique opportunity to evaluate figure drawings as a screening test. After a suitable classification has been formulated, one can determine whether or not the figure drawings of various kinds of subjects are significantly different from each other.

It is the purpose here, then, to present a series of studies in regard to figure drawings, their scoring classification and their use in the appraisal of personality in a population of healthy medical students on whom a wide variety of other data are available. Comparisons will be made between the figure drawings of smokers and nonsmokers, of subjects with and without parental histories of hypertension and/or coronary artery disease, with and without hypercholesteremia, and with different types of body build. In the present paper the literature concerning figure drawings has been reviewed in an attempt to provide a broad background for the projected studies.

Part I—Concept

1. *Historical Background*

The use of human figure drawings as a projective device for personality assessment is relatively recent. Its origin in its simplest form of expression of perception, experience, or observation, as the case may be, is traceable to our primitive ancestors in the later paleolithic age. It may be worth noting, however, that

records of cave drawings report that human figure drawings were outnumbered by drawings of animals. Those that did appear were usually grossly exaggerated female forms. Drawings of animals were chiefly profile drawings.

Goodenough[3] summarizes the historical beginnings of using drawings as a means of insight into human mental characteristics. She reports recorded evidence of observations relating children's drawings to the children's mentalities as early as 1885 in England. Subsequent related observations were made in France, Germany, Switzerland, and Belgium. Scientific interest in children's drawings began to be manifest early in the twentieth century even to the extent of the development of a simple scoring scale. A series of age norms applied to drawings of the human figure first appeared in Belgium. In Germany qualitative as well as quantitative differences were detected in drawings of feeble-minded and normal children. Between 1901 and 1918, in France, Germany, and the United States, the thesis began developing that drawings might throw some light on mental disorders.

The first use of a human figure drawing as a reflection of a personality attribute appeared in the Goodenough Draw-A-Man Test of intelligence. This test has been validated against other intelligence measures and has extensive use. As the use of the test expanded, differences other than those denoting intelligence level became apparent in the drawings. Goodenough stated that it is "hard to escape the conclusion that, however unimportant these matters may seem, they probably carry a profound meaning, had we but the wisdom to understand it."[3, p. 60]

It was from the use of the Draw-A-Man Test that Machover concluded that "careful study of the individual drawings often yielded rich clinical material not related to the intellectual level of the subject."[2, p. 20] With approximately 20 years of experience in intensive study of drawings in relation to other clinical data on individual subjects, Machover developed the principles of a method for the clinical use of the Figure Drawing Test, and in 1949 published an exposition of her method.

At about the same time another drawing test known as the House-Tree-Person Test was developed. This was also designed to measure intelligence level but yielded evidence of characteristics of differentiation other than those identified with intelligence. Anastasi and Foley[4] made an extensive survey of the liter-

ature on artistic behavior in the abnormal which provides a rich reference background. Machover[2, pp. 19, 20] does not agree with their conclusion "that differentiations through drawings could only be made in the presence of extreme mental disorders and only with individuals who offer personalized, startling, or bizarre productions." She believes that analysis of individual personality as well as group characteristics must eventually develop out of the use of the figure drawing projective technique "and be referred to a basic and stable rationale."

2. *A Personality Measure*

The deviation of human figure drawing from the original purposes of the House-Tree-Person Test and the Draw-A-Man Test has been primarily in the direction of diagnosis of mental disorders. Research in the past decade in the use of the Draw-A-Person Test has begun to explore its possibilities for the measurement of personality in normal individuals.

Abt,[5a, pp. 46-58] referring to both Piaget's and Sheriff's theories of perception and personality, presents a theoretical basis for the use of projective devices in the interpretation of personality. He points out that when an individual is deprived of, or detached from, explicit and known relationships in his surroundings, anxiety is heightened. Presented with an unstructured situation, he is forced to rely upon internal factors of perception to cope with the situation. To reduce the anxiety he feels, he seeks "psychological homeostasis" by using projective mechanisms. An unstructured testing device is therefore invested with an expression of his needs, defenses, and fantasies. The human Figure Drawing Test presents one of the most unstructured situations among the projective testing devices.

Using Abt's assumption, it may be presumed that figure drawings have a potential for revealing attributes of personality. If this is true, then research in the use of figure drawings may be expected to explore the evidences of common defenses against threats to security and personal integrity, such as inflexibility, prejudices, hostility, aggression, overactivity, and sexual assertiveness, as expressed in figures drawn by normal as well as by abnormal individuals. "Apperceptive distortion" has been defined as a subjective interpretation of a perception meaningful to the person making it. It is the apperceptive distortion made by the

subject which the interpreter looks for in an analysis of figure drawings.[5a, pp. 12-31]

3. *Relatedness to Body Image*

Witkin sees a close relationship between perceptual performance and a relatively well-defined self-concept, as shown by the Figure-Drawing Test.[6, p. 478] The projection of body image in figure drawings is the subject of investigation in various research studies. "The body, or the self, is the most intimate point of reference in any activity. We have, in the course of growth, come to associate various sensations, perceptions, and emotions with certain body organs. This investment in body organs, or the perception of the body image as it has developed out of personal experience, must somehow guide the individual who is drawing in the specific structure and content which constitutes his offering of a 'person.' Consequently, the drawing of a person, in involving a projection of the body image, provides a natural vehicle for the expression of one's body needs and conflicts."[2, p. 5]

The term body image is not to be confused with various other applications of the term *body,* according to Fisher and Cleveland. These investigators define the term as follows: "*Body image* is a term which refers to the body as a psychological experience, and focuses on the individual's feelings and attitudes toward his own body. It is concerned with the individual's subjective experiences with his body and the manner in which he has organized these experiences. The assumption is that as each individual develops he has the difficult task of meaningfully organizing the sensations from his body—which is one of the most important and complex phenomena in his total perceptual field. . . . Actually the term *body image* involves no assumptions regarding the availability to conscious knowledge of such attitudes and feelings. . . . *Body image* may in certain respects overlap the various usages of concepts like *ego, self,* and *self-concept.*"[7, pp. x-xi] In general, the use of the term body image in the literature on figure drawings seems to follow this description.

Anastasi comments that research on "perceptual functions as a possible approach to the understanding of personality differences antedates research with objective tests and factor analysis."[8, pp. 353, 356] She judges Witkin's 10-year study to be "one of the most ambitious projects on perception and personality" in which

scores were developed for converting results of projective tests, interviews, and specific space-orientation perception tests into terms of personality analysis.

Part II—Aspects of Research

1. *Differentiation*

Kinds of Differentiation—

A study of differentiation among various aspects of behavior and factors of personality offers a fertile field of investigation in the use of figure drawings as a projective technique. The term applies both to the structure and to the content of figure drawings in their reflection of personality differences in individuals. An arbitrarily chosen classification serves the purpose of grouping kinds of differentiations which appear in the considerable variety of studies reported: body image; sexual identification and differentiation; types of personality maladjustment; disparate age levels.

Body Image—

The concept of body image may be considered a focal point among kinds of differentiations. Detailed aspects of personality development or deterioration are frequently treated in a close relationship to the central concept of reflection of body image in figure drawings.

Buck[1] in 1948 found from the objective analysis of his House-Tree-Person Test that certain items differentiated between normal individuals of various levels of intelligence. He also noted evidence that nonintellectual qualities were reflected in the drawings, and he applied similar evaluative criteria to them for differentiation. He emphasized, however, that in making such differentiations, items should be considered in configurations, since they may possess totally different meanings in different configurations.

The theoretical concept of the figure drawing as a reflection of body image or self-concept is supported by a number of authors and investigators and considered doubtful by a few.[9-11] Witkin[6] produces evidence that a relationship exists between an individual's concept of his body and his interaction with his environment, and that this relationship is expressed in personality functioning. Schilder, theoretically, holds the thesis that body image is to a considerable degree the product of socialization; that if

an individual's interactions with others are faulty, his body image will suffer in its development. Fisher and Cleveland consider the Witkin study "the most clear-cut and definitive in the whole body-image literature."[7, pp. 31, 34] However, they consider that in the range of studies of figure drawings there are "issues rather far afield from the body-image." Berman and Laffal[12] concluded, from a comparison of body type of subjects and of figures drawn by them, that, within the limits of their study, a person drawing a human figure reflects certain concrete aspects of himself, that he makes a projection of his body image. Self-concept changes were said to be reflected in the figure drawings of a patient under ACTH treatment for exposure to beryllium dust, as the patient progressed in response to treatment.[13] Changes in body image projected in figure drawings that were related to psychotherapeutic changes more closely than could be accounted for by chance were reported by Kosseff.[14]

Other studies between 1949 and 1959 present evidence of differentiation of various factors in self-identification closely related to the over-all theory of self-concept or body image revealed in human figure drawings. These studies used a variety of subject populations: obese and non-obese women;[15] normal and psychiatric subjects;[12, 16-19] subjects with physical disabilities[20] and children, young adults, and aged persons.[21-23] The Witkin study has specifically indicated that differences in personality reflected in figure drawings relate to the theory of body image and personality.[6, pp. 247-252, 467-473] Two studies undertook to determine the degree of self-consistency appearing in any one individual's successive drawings of a person. A test was administered to college students, with no comments about the possible implications. Afterward, the subjects were given a lengthy explanation of the possible negative interpretations to be found in figure drawings. They were then asked to make a second drawing in the same manner as the first. From the results obtained, the author concluded that: "... the Human Figure Drawings continued to reflect a consistent picture of the self-image, despite attempts to disguise or conceal what they knew or imagined to be significant details relative to weaknesses in their own personalities."[24, p. 386] In the other study,[25] a time interval intervened between two administrations of the test to a group of college students. According to the investigators, there was no evidence that the time lapse affected the character-

istics of the drawings or that the data could be interpreted as a function of "set" on the part of the subjects.

Sexual Identification and Differentiation—

Sexual identification and differentiation may be viewed in three categories of measurement: maturity, qualities of masculinity and femininity, and sexual inversion.

MATURITY. One team of investigators, using subjects below and approaching adolescence, concluded that sexual differentiation in drawings increases as age progresses and that correct identification is a manifestation of maturity. Improvement in sex differentiation did not appear to be related to the tendency to draw the self-sex first.[26] In another study in the same year, Swensen reported that he found mature sexual identification concomitant with clear and correct differentiation in figure drawings.[27] Davidson[28] made a cultural study of groups of children in the Virgin Islands and in the United States. An inference in this study links cultural influence and sexual identification. Children in the Virgin Islands in most instances drew the male sex first while the group in New York showed the reverse tendency. Mainord[29] suggests that the drawing of the opposite sex first by females may be the result of the influence of an androcentric society. The Witkin study[6, pp. 435, 436, 437] shows that drawings of immature adults and young children have characteristics in common which include meager sex differentiation. In their drawings of the female, boys aged eight to 13 reflected characteristics interpreted as indicative of increasing independence, while at later ages, these characteristics were modified to reflect "a heightened and more realistic interest in girls." In the same long-term study, scores from figure drawings of women are interpreted as reflecting less mature body concepts and a greater dependence on environment than do men's scores. This interpretation is further linked with culturally and biologically defined sex differences.

MASCULINITY-FEMININITY. There seems to be only an artificial line of demarcation between the effects of cultural influence as indicated in sexual identification, and characteristics of self-concept commonly interpreted as reflections of masculinity or femininity in our culture. Swensen and Sipprelle[30] assert that men's and women's drawings of the male and female reflect differences in masculinity-femininity characteristics. The sexually differentiated

characteristics of drawings reported in the Witkin study[6, pp. 486-487] are not described under the commonly used masculinity-femininity term, yet the differences reported are clearly sex-identified: "There is also some evidence that body projection, as reflected in Figure-Drawing Test performance, may be more intimately related to personality functioning generally in men than in women. ... The differences we have found between men and women in patterns of intercorrelations among personality scores, and between personality and perceptual scores, although they are not great and although they clearly require confirmation through further studies, are consistent in relation to one another. They suggest that the relation between attitudes toward the body and other aspects of psychic life is closer in men than in women. In other words there seems to be greater identity between body and 'self' in men than in women."

Holtzman,[31] chose a hypothesis designed to test the effect of the examiner on the drawings of male and female subjects. He concluded that there were no variations in drawings which could be attributed to qualities or characteristics of the examiner, but that highly significant differences found could be attributed to the sex of the subject.

Sexual inversion. Four of the studies examined were designed specifically to identify the homosexual individual through characteristics reflected in figure drawings. Barker et al.,[32] using a Machover check list, found that many of the figure-drawing characteristics for male homosexuals described in the literature were not present in the drawings of the group of male homosexuals used as subjects in their study. They found no evidence to support Machover's empirical conclusion that homosexuals tend to draw the opposite sex first.[2, p. 101] Mainord's study[29] also relied heavily on the Machover system. Her data gave support to the hypothesis that drawing the opposite sex first is a possible sign of sexual inversion, to the extent that she found possible validity for males but not for females. Neither DeMartino[33] nor Grams and Rinder[34] found signs in the figure drawings of their subjects which they considered predictive of homosexuality.

Types of Personality Maladjustment—

More than half of the studies examined for this review used psychiatric patients or persons with major personality maladjust-

ments as subjects, sometimes in comparison with normal subjects as control groups. Specific purposes of the studies were to differentiate between levels of maladjustment or between a category of psychiatric patients and one of normal persons. One team of investigators[35] found that the use of a formal graphic scale differentiated, with statistical significance, between normal and schizophrenic subjects. Two years later the same scale was applied to a new population with similar significant results.[36] In studies in 1949 and again in 1950, Albee and Hamlin[16, 17] found a relatively high correlation between the judgments on the drawings of patients in a Veterans Administration mental hygiene clinic and in the case records of the subjects. The scale used was found to discriminate between normal and neurotic persons and between normal persons and schizophrenic patients but not between neurotic and schizophrenic patients. Stonesifer,[37] using the Goodenough scale, attempted to differentiate between schizophrenic and nonpsychiatric subjects. His results were negative.

Reznikoff and Tomblen[18] found no significant difference between drawings of neurotic and schizophrenic subjects. Royal[19] found some differentiating characteristics in the drawings of normal and of neurotic subjects.

Fisher and Fisher[38] found that the majority of the drawings of paranoid schizophrenic patients did not fall under the paranoid category of the Machover system and that two methods of analysis used did not correlate. The same investigators,[39] in a later study, found sexual differentiation of disturbed women reflected in figure drawings, and considered this to be meaningful in the prediction of sexual adjustment and general personality integration. Sherman[9, 10] and Whitmyre,[11] in separate studies made five years apart, presented negative results for the value of the figure drawings as a differentiating instrument. Both men concluded that the art quality, rather than personality characteristics, provided the criteria in an inspection method of analysis.*

Disparate Age Levels—

Lakin[21, p. 473] was interested in the possibility that there were changes in body image reflected in figure drawings at disparate age levels of the individual. He applied formal criteria to the drawings of normal children and to institutionalized aged adults.

*Cf. Part III, 4. "Artistic vs. Projective Significance."

His findings confirmed his hypothesis that aged subjects draw more constricted, shorter, and less adequately centered figures than do normal adults, and that children's drawings are more like those of normal adults. He further concluded that his findings support the assumption that formal aspects of figure drawings "are related to the central variables of self-conceptualization and body-image." A group of three research workers[23] compared drawings of two different age groups, graduate psychology students and adults aged 60 to 90. Their conclusions were similar to those of Lakin.[21]

Lehner and Silver[22] made an analysis of normal subjects between the ages of 17 and 54 with the purpose of finding the relationship between the subject's own age and the age which he ascribed to the male and female figures of his drawings. The results reflected differences between the two groups, which were sexually and culturally influenced. Witkin[6] found that the drawings of young children were paralleled, in many of the items evaluated, by the drawings of hospitalized psychiatric patients and that these were items which appeared less frequently in the drawings of normal adult women.

KINDS OF CRITERIA—

There has been a marked trend toward replacing or supplementing the initial clinical type of evaluation with objective, or formal, graphic scoring techniques. While not all of the published reports define or describe specifically the nature of the criteria applied in evaluation of figure drawings, at least 15 of the reports examined do indicate or describe check lists of such specific items derived from empirical study of many drawings and from descriptions appearing in the literature.[6, 15, 18, 21, 24, 25, 31, 35, 36, 40-45]

Objective or graphic criteria vary from a general classification in three categories—perspective, detail, proportion in one case[1] or area, height, centeredness in another[21]—to detailed analysis of features, body, appendages, clothing, etc. numbering as many as 174 or more items.[21, 35, 36, 41] Other investigators[46] have applied personality items that were developed as empirically determined correlates of drawing characteristics. Relatively few have reported studies based solely on an intuitive, impressionistic use of criteria in attempting to find differentiating qualities of figure drawings.[2, 5c, 32, 47b] Criteria scales for matching and comparison have made use of the global inspection type of application as contrasted

with the application of detailed check-list criteria.[16, 17, 27] Fisher and Fisher[38] present one of the few studies in which two types of criteria, detailed atomistic and total impressionistic, are applied in a test of validity of differentiation.

SUMMARY

Evidence is too limited to permit generalizations regarding the values of the figure drawing as an instrument for differentiation of personal characteristics. Data accumulated thus far seem of only fragmentary significance. There appears to be a probability that the figure drawing will become a valid predictor of some kinds of differentiations if relatively standard sets of criteria are used and if interpretations can be achieved which are not subject to the influence of judges' backgrounds and training. At present, hypotheses for which substantiating evidence has been produced seem to stand in isolation from each other. They need to be joined by repeated studies testing the same kinds of differentiations evaluated under a variety of circumstances. Those hypotheses for which there seems to be some progress toward verification are in the areas of self-identification, some aspects of sexual differentiation, and of age and maturity differentiation. In general, throughout the literature, there is a variety of kinds and degrees of differentiation with lack of consistency in test and retest of any one kind or degree, by any one technique or set of criteria.

2. *Methodology*

PROCEDURES—

Administering the test—

Simplicity of administering the Draw-A-Person Test is one of the characteristics which sets it off as unique among both projective and nonprojective tests. There is no disagreement among differently oriented psychologists about procedures for administering the test. Detailed descriptions are brief and almost identical as they appear in several basic sources of information.[2, 5, 47b] Few research reports spell out the details of administering the test, however. It is apparently taken for granted that the Machover procedure is the generally accepted one and that the simple details do not need repetition, that anyone familiar in any degree with the Draw-A-Person Test is familiar with how it is administered.

Methods of Analysis—

As has been shown previously, clinical psychologists rely on interpretive synthesis of data from figure drawings, often as fragmentary or isolated samples which do not offer public and explicit data. In contrast, psychologists working by experimental and statistical techniques are intent upon the use of explicit hypotheses with controlled methods which can be duplicated and interpreted in the language of quantitative mathematics.[5, 47] Macfarlane and Tuddenham[47a, p. 28] sum up the problem as follows:

> We are confronted as scientists with a challenge to see if we have enough imagination to develop research methods that will organize in a public, repeatable, objective fashion the multifactor data that the skilled clinician organizes by unpublic interpretive synthesis. To date it is clear that the clinician has already made much progress in understanding personality in spite of, or perhaps because of, the fact that he has ignored many of the contemporary scientific folkways. As scientists, we still insist that the processes by which a clinician synthesizes his material are not beyond discovery, and that eventually we shall be able to correct his subjective errors and make his methods public.

The same authors define two procedures for securing qualitative data from projective tests: "matching, which deals with a subject's record as a whole, and coding classification or rating scales, which deal with selected aspects of the record. . . . Whereas the method of matching attempts to treat materials as a whole, coding and rating approaches break down the material into parts and attempt to measure the degree of stability with which these parts can be assessed."[47a, pp. 36-37]

Most of the research reported in the past decade has been developed along lines which attempt either to achieve a compromise between two types of procedures or to demonstrate a procedure which can be duplicated and explicitly understood by all psychologists.

Matching. Various forms of matching procedures have been used. To a considerable extent, these methods are dependent upon intuitive or global impressions. The paired comparison method used by Albee and Hamlin[16, 17] is one such combination. Others using some form of comparison or matching are Berman and Laffal,[12] Lehner and Silver,[22] Sherman,[9] and Swensen.[27] Comparison with records of patients as criteria, with body type and with drawings assigned rank values, make up the matching procedures to be found in these studies.

CODING AND RATING. The majority of investigations reflect a trend toward using procedures which have specific objectives and which attempt to produce quantitatively significant data and predictive criteria. Rating scales are the instruments for systematic study and analysis of figure drawings designed to find scientific respectability for the test. Little duplication of procedure for verification of stability of assessment is to be found among these studies. One source comments specifically on the "rash of scoring systems proposed by other workers" which follows the publication of a projective device.[47a, p. 38]

DeMartino[33] used a scale adapted from one used by Holzberg and Wexler[30] in two studies. The graphic manual devised by Steinman[45] was used in two separate studies by Graham.[24, 40] With these exceptions, each investigator pursued his own method of evaluation.[6, 14, 15, 18, 19, 21, 25, 42] A combination of inferential methods with coding and rating methods appears in studies by Blum,[48] Cramer-Azima,[13] Davidson,[28] Fisher,[49] and Buck.[1]

INTUITIVE APPROACH. The outstanding exponents of the intuitive procedure are Machover[2] and Levy.[5c] Barker et al.,[32] in an exploratory study of signs in figure drawings purporting to identify male homosexuality, used the Machover technique. Modell and Potter[50] used eight categories of psychodynamic characteristics as a basis for content analysis of drawings in a study of patients with hypertension, peptic ulcers, and bronchial asthma. Cowden[51] recommends the intuitive method in preference to a detailed analytical method. Steinman[45] compared two methods of evaluation, one of which was an opinion or intuitive evaluation. One purpose of the study was to determine whether there was a difference in ratings made by the opinion method and by the manual of weighted graphic items.

Statistical Treatment of Data—

Treatment of data from research using the Figure Drawing Test ranges from impressionistic opinion statements as sole support of claim to reliability through the full gamut of statistical computation for testing reliability and validity. Albee and Hamlin[16] present one of the earliest records of any attempt to find statistical corroboration of clinical claims of reliability and validity for the Figure Drawing Test. Paired comparisons of drawings were set up according to a statistical formula. The mean

preference for each of two groups of judges was determined and converted into scale values. From these scale values, a linear correlation was computed between the two groups of judges. Rank order correlations were computed between case records and the judgment consensus of judges, and tests of significance were obtained on the reliability and validity coefficients. In a succeeding study,[17] the same investigators applied χ^2 testing for significance, in comparing differences among three groups of subjects.

Other investigators report statistically significant differences through the use of the χ^2 test: Kotkov and Goodman,[15] between pilot and experimental groups; Schmidt and McGowan,[20] between drawings of two groups and between judgments of two groups of judges; Swensen and Sipprelle,[30] between groups of patients.

In the Steinman study[45] correlations were computed between the rank evaluations of figure drawings and ranks established by the histamine tolerance of subjects. Both rank correlations (rho) and coefficients of correlation (r) were computed on opinion rankings of the drawings, and later on rankings resulting from the use of the manual. Graham[24, 40] and Holzberg and Wexler[26] applied the *t* ratio as a test of significant differences for discriminating between two groups, each in two separate studies. Berman and Laffal[12] computed the Pearson *r* correlation, both in setting up their criteria and in testing results. Swensen[27] and also Holtzman used the same process in determining relationships between judges' ratings.

Summary—

The authors of most of the studies just referred to have concluded that their statistical findings are sufficiently significant to reject the null hypothesis. The use of statistical procedures has demonstrated to a great degree that an objective method is applicable in a study of differences in figure drawings or of differences in subjects producing the drawings. Data are on the whole fragmentary and as yet unsystematized, insofar as being related to any over-all purpose and function of the Figure Drawing Test. The nearest approach to any justifiable generalization emerging from these studies is that—with but few exceptions—there is an absence of duplication and re-test of methods. Macfarlane and Tuddenham[47a, p. 40] suggest a reason for this lack: "Many projectivists have made the assumption that their tests assess basic personality with-

out error of measurement, and therefore they have no interest in creating alternative forms to determine the amount of error." They further point out the difficulties to be met in creating "equivalent forms."

A common denominator for figure drawing studies for predictive purposes appears more often in the basic procedures in the handling of data than in the hypotheses to which they are applied. It is not always clear whether the research is designed to demonstrate a method and prove it scientifically, or to provide validation for some particular use of the figure drawing. Macfarlane and Tuddenham[47a, p. 51] bring a problem into focus as follows: "Especially since analysis of variance methods became popular, many research designs have been planned to refute the null hypothesis with respect to the association between test and criterion. However, if the samples are large enough, one may prove statistical significance when the association is a weak one. Since, in practice, tests are nearly always used as a basis for predictions about individuals, no test can be regarded as having satisfactory validity unless it can be shown to reduce the error of estimate enough to justify the time and effort involved in giving it."

Witkin[6, p. 514] sees a need for modification of procedures on the part of both the experimental and the clinical psychologist: the former to evidence greater concern for the individual away from the strictly laboratory setting; the latter to gather facts under conditions subject to better controls and with more attention to psychological functioning. He sums up by offering what seems to be a functional admixture of two systems for use in continued research with the figure drawing: "There is obviously no sharp line of demarcation at the point where the experimental approaches and shades into the observational method, and usually a method is identified as experimental when it involves a fair degree of control over conditions. Method, in each case, must be determined by the phenomenon being studied, and one does not necessarily show himself a better scientist by virtue of choosing the experimental rather than the observational approach."

Scoring Devices—

Early Developments—

In 1926 Goodenough[3, p. 60] published results of the development and use of objective criteria for the analysis of drawings of the

human figure in the measurement of mentality. As hundreds of drawings were analyzed striking individual differences were noted, which led Goodenough to conclude that the drawings very probably indicated characteristics other than intelligence. The analysis of drawings for clinical uses differed from that of the Goodenough Draw-A-Man Test of intelligence, in that it was essentially qualitative, subjective, and to some extent nonverbal. Subsequently, under the influence of experimental and statistical procedures in psychology, research workers began to devise scoring techniques which could be translated into quantifiable data for purposes of testing the validity and reliability of the test.

Kinds of Scoring Devices—

IMPRESSIONISTIC, CLINICAL ANALYSIS. Ambiguity in meaning sometimes results from terms used in reports of clinical analyses of figure drawings. A "clinical rating *scale*," as used by Machover, is not clearly differentiated from the intuitive, the impressionistic, the global, or the inspection type of rating. The best known of all clinical type evaluations is reported by Machover,[2] resulting from her years of collecting figure drawings and comparing them with identified diagnoses of clinical patients.

Varying adaptations of the Machover system have been used in the following studies:

Modell and Potter[50, p. 282] used an impressionistic content analysis without quantifiable scoring for the purpose of delineating "personality traits and conflict problems that have been described in patients with hypertension, peptic ulcer, and bronchial asthma."

Barker, et al.,[32, p. 186] for identification of male homosexuals, used Machover's "Outline of Interpretive Features" with no quantitative scoring. They stated that a "trained clinician is well aware of the danger involved in applying normative generalizations to an individual drawing."

Blum[48] used the Machover interpretive system as one of the rating forms compared in his study of personality characteristics in neuropsychiatric patients. Psychologists, as judges, used their own impressionistic technique.

Schmidt and McGowan[20] used an inspection type of analysis for placing drawings in their appropriate group for differentiation between two groups. A "right" and "wrong" rating was applied to the placement, the order of placement tabulated, and results statistically computed.

Grams and Rinder[34] converted interpretations on 15 Machover items with a "present" or "absent" notation into a statistical conclusion for the validity of the human figure drawing as a predictor of homosexuality.

Swensen's evaluative review of the literature on figure drawings[52, p. 463] from 1949 to 1956 examined the Machover hypotheses and discounted the conclusions resulting from use of her evaluative technique as viewed in the light of other research. Hammer,[53, p. 32] in a critique of Swensen's evaluation, supports the impressionistic analysis with the following statement: "In the face of a complex world, the research worker is obligated to recognize the complexity of the variables he attempts to come to grips with in his investigations, and steer vigorously away from the dangers of atomistic studies, naïvely conceived and dogmatically interpreted."

PERSONALITY ITEM ANALYSIS. Specific personality items were used by several investigators as criteria for the measurement of figure drawings:

Fisher[49] used 80 personality variables selected from 400 descriptive statements of personality occurring in three textbooks on the use of projective techniques. These variables, applied in an analysis of drawings, were treated statistically. Personality descriptions inferred from drawings were compared with descriptions derived from other sources of clinical data.

Kotkov and Goodman[46] attempted to equate specific personality traits with specific graphic items applied in the measurement of drawings. No positive correlation was achieved between the two for a prediction of personality.

Blum[48, p. 123] devised a rating scale which was "a condensation of all possible interpretations into related and consistent general personality characteristics including specific sub-areas of personality specified by Machover." Thirty-eight characteristics in all were used by psychologists and were redefined, modified, and reduced to 23 items for use by wardmen as raters on the drawings of 31 patients.

As a form of analysis this personality item category is so infrequently used that it merits attention only because it appears as a slight variation from the Machover system.

CONTINUUM CRITERION SCALE. The continuum scale as a basis for evaluation appears in four studies:

Albee and Hamlin[16, 17] developed a continuum of scale values as a criterion base in a study designed to determine the reliability and validity of figure drawings in identification and diagnosis of psychiatric patients.

Blum[48] used a three-point continuum scale in combination with other ratings on subjects. Minimal, moderate, and maximal constituted the three points of the scale.

Swensen[27] used a five-point scale with graphic characteristics of drawings. Condensed descriptions identified each point of the scale ranging from "little or no" through "poor, fair, good" to "excellent."

GENERAL GRAPHIC CHARCTERISTICS.

Buck[1] in 1948 reported on a use, as early as 1938, of a point-score system applied to the House-Tree-Person Test which he considered to be more objective than analysis inspection for evaluation of drawings. Norms were established from items of detail, proportion, and perspective. These items were serially numbered and assigned factor symbols. Originally designed for the purpose of differentiating intellectual qualities of individuals, the scoring techniques appeared to the investigator to have significance also for the differentiation of nonintellectual qualities. For the latter use, items were broken down into many subheads.

Royal[19] developed a check list of 28 graphic items which, when defined, yielded 18 scoring points with potential for differentiation. Eight points were combined into a scale from which he found a substantial relationship evidenced between points in combination and particular arrangements of frequencies in both halves of the groups studied.

Kosseff[14] used linear measurements on nine graphic characteristics of drawings. Graphic traits and personality traits were compared in an attempt to determine the effects of psychotherapy on a patient's body image.

Lakin[21] used linear measurements for three formal variables as a rating device in his validity study of the figure drawing as a reflection of self-concept or body image.

Starr and Marcuse[25] used seven characteristics as criteria in checking the reliability of figure drawings when the test was administered by different examiners after an intervening time.

SPECIFIC GRAPHIC CHARACTERISTICS. The move toward achieving greater objectivity as a basis for testing the value of the Draw-A-Person Test is marked in the number of investigations using specific graphic characteristics as criteria items.

Goodenough,[8] prior to the period covered by this review, devised an objective scoring scale for the Draw-A-Man Test. A scale of 51 points, specifically identified and defined, resulted from a detailed preliminary study. The specific graphic indicators, scored by a plus-minus check, were converted into numerical scores. The scale, according to the author, was not difficult to apply but required a mastery of directions for its use.

Oakley[24] devised a scale for psychological measurement of children from drawings based on composite drawings, and a standard representation for each point of the scale (e.g., length of arms, details of ear, lips, etc.).

Holzberg and Wexler[31] developed a check list of 174 specific items for the objective analysis of human figure drawings. The rating instrument

was entirely graphic, with specific definitions used to give objectivity to doubtful items. The same scoring criteria were used in a follow-up study two years later, with results which the authors believed confirmed the findings of the original study.

Lehner and Gunderson[42, p. 126] used 21 graphic traits of drawings for ratings in a reliability study, "... each trait described by a set of mutually exclusive descriptive categories, usually 10 for each trait, in terms of which the ratings were made."

Davidson's check list[28] comprised a total of 125 items made up from characteristics appearing in drawings collected in her investigation.

DeMartino[33] used a check list derived from the Holzberg-Wexler list,[35] one of the few scoring devices referring to the work of another investigator.

Steinman[45] constructed a manual made up of 59 features empirically constructed from drawings of 66 subjects who were patients in a mental hospital. The items of the manual were given variable value weightings from which scores were derived. Steinman used this manual as a comparison base for intuitive and objective scale types of scoring. Graham[24, 40] used the Steinman manual for two studies appearing in 1955 and 1956.

The Witkin study[6] combined, into a scale, specific graphic items associated with personality variables. The same scoring scale which had been developed for use with the Rorschach was used for the graphic items of figure drawings for purposes of discrimination between subjects with different perceptual performance. A short scale, 40 items for men and 45 for women, was derived from an original long scale of 88 items for men and 98 for women. The total number of graphic items appearing in the drawings made up the score. Nowhere in the literature reviewed is there a more detailed descriptive account of a scale used for objective and quantifiable evaluation of figure drawings.

Reznikoff and Tomblen[18] assembled 17 graphic indicators for use in a study of the reliability of the Draw-A-Person Test for diagnosis of maladjusted patients. Four items were discarded from the original list—two as unscorable, two for duplication. A plus-minus system of scoring was used. Five of 14 items were found to indicate differentiation. A later study[43] with different groups of subjects used 26 items, which were applied for a different type of discrimination. Only three of the 26 were found to have discriminating value in this case.

PHYSICAL CRITERIA: BODY TYPES, BODY PARTS. Although only two studies in those reviewed were concerned with body type and body parts as a basis for scoring criteria, this classification is set somewhat apart from others:

Berman and Laffal[12] used body types as described by Sheldon et al.* as basic criteria in attempting to determine relationship between the subject's body type and that of the figure drawn by him. A comparison method was used for identification of the drawing as endomorphic, mesomorphic, or ectomorphic in type.

Feldman and Hunt[55] used a listing of 25 body parts in rating figure drawings to determine whether there was any relationship between difficulty in drawing and rating of adjustment.

PERSONALITY ITEMS AND GENERAL GRAPHIC ITEMS IN COMBINATION. The categories arbitrarily chosen for reviewing kinds of scoring devices used in research are not mutually exclusive. One type of device may be used in conjunction with another as has been evident in some of the descriptions presented. This is particularly true in personality item analysis.

Kotkov and Goodman[15, 46] embraced a combination of general graphic items and personality trait items in their study of obese women and women of ideal weight. In the first phase of the study, drawings were evaluated for differentiation on the presence or absence of selected graphic items. In the second, a rationale of personality characteristics was inferred from the differentiating graphic items, and these were compared with certain assumptions regarding personality traits of obese women.

In the total evaluation of her case study Cramer-Azima[13] combined content analysis by inspection with a graphic evaluation of structure of the patient's drawings. This combination is an illustration of Abt's position[58, p. 64] that "we must be prepared to abandon the spurious distinction between quantitative and qualitative data . . .we must develop techniques of data treatment which permit us to handle both types."

Trends in Scoring Methods—

It will be noted that within some categories just discussed, as few as two studies provided the basis for the classification. The sparse distribution of studies—under varied, arbitrarily designated kinds of scoring devices for the Draw-A-Person Test —indicates that research in the direction of development of reliable reference standards has as yet achieved only a random approach. It has been pointed out that clinical psychologists see little if any probability of standardization by scoring scales and that to many it seems inappropriate to have a projective test so standardized. On the other hand, the pressure of experimental and statistical psychologists is exerted in the direction of stand-

*Sheldon, W. H.; Stevens, S. S., and Tucker, W. B.: The Varieties of Human Physique. Harper. New York. 1940.

ardized assessment criteria or common standards of reference. Morris,[56] in a methodological consideration of the use of the figure drawing as a projective technique, was of the opinion that reliable scoring of drawings is possible but that there is need of careful scientific and systematic study in the preparation of objective scoring procedures.

If the percentage of studies using some form of scoring scale or device other than intuitive evaluation is an indication, it may be said that the trend is strongly in the direction of finding some "reliable reference standard" by way of objective assessment criteria for figure drawings. However, the development and use of lists of items of assessment does not in itself produce a reliable reference standard. A scoring scale is more than a list of items. A scale must have successive points of value with which items can be identified. Items may be regarded as variables with different values in the total scheme of evaluation, or they may represent constant or absolute criteria. The use of variability value in assessment appears to lie between two extremes: views of clinical psychologists on the one hand, and views of experimental and statistical psychologists on the other. Few studies have developed the combination illustrated in Buck's work[1] and stressed by Abt.[5a, p. 64*] The "present-absent" or the "plus-minus" scheme disregards the variability value. The continuum represents a partial weighting system with a differential point range. The number of points within this range, though giving recognition to variability, may or may not be treated as numerical weightings for a quantitative evaluation.

Summary—

Of the studies treated in this section, 15 used no weightings and thereby attached no variability of value to an item used in rating. Three used a continuum or point system. Three used the "plus-minus" or "right-wrong" scheme with a frequency check. Three used linear measurements as scores. Six used weighted scales in scoring. The question of superiority of any one device or system can be answered only in terms of reliability and validity. Since reliability and validity are treated as a separate topic in this paper, the answer to the question can be more appropriately sought under that heading.

*Cf. Part II, 2. "Methodology," etc.

JUDGES AND THEIR EVALUATIONS—

Qualifications and Selection of Judges—

Throughout the literature judges are for the most part classified as psychologists and nonpsychologists. They may be identified as professionally competent or as highly skilled and experienced practitioners, as distinguished from "the novice or psychiatric dilettante."[51] Finer distinctions are made among some psychologists. Clinical psychologists may be those with experience in the analysis of figure drawings or those without. According to Schmidt and McGowan[20] they may have "affective professional orientation" or "cognitive professional orientation" to drawing analysis, or they may have only the general designation of psychologists with Ph.D's.

Under the heading of nonpsychologists, persons with various kinds of experience and education have been used. Albee and Hamlin,[16, p. 391] after using clinical psychologists as judges for testing the reliability of figure drawings by "global or insightful impressions," seemed to favor the use of less experienced judges, since they stated that from "other data not yet completely analyzed, it appears that non-clinical psychologists, not experienced in projective techniques, can make as reliable judgments." Nevertheless, a follow-up study[17] a year later indicates the continued use of psychologists.

Partial deviations from the predominant tendency to use clinical psychologists as judges appear in seven more or less experimental studies on validity. Blum[48] used chief wardmen in a veterans' hospital as judges, in addition to psychologists and psychiatrists. Fisher and Fisher[38] added stenographers to psychologists and psychiatrists as raters of figure drawings of 32 paranoid schizophrenics in the comparison of two methods of analysis. Some investigators have used both artists and clinical psychologists as judges in attempts to determine the validity of figure drawings with respect to personality adjustment level.[9-11, 55, 57]

In the Witkin study,[6, p. 239] the problem of qualifications of judges was simplified, avoiding the necessity of using persons expert in a highly specialized technique of interpretation. Goodenough,[3] in the use of the Draw-A-Man Test for measurement of intelligence, specifies qualifications for judges, only by pointing out that scoring is not difficult but that it requires mastery of directions. In contrast, other investigators insist upon the use of the skilled

clinical psychologist or the professionally competent person as judge of figure drawings for personality study and evaluation.[5c, 51]

Thus the literature on the subject of figure drawings reveals no standard criteria for the qualifications of judges or raters. Criticisms—made by psychologists in experimental and statistical fields—of projective techniques for their subjectivity and nonexplicit interpretations have led to explorations in the use of judges without highly specialized training and experience in the interpretation of figure drawings. Except in a relatively small number of experimental situations, highly specialized judges have been selected where only qualitative techniques are employed or those techniques variously known as the "inspection method," the "molar," "global," and "intuitive" approach or an impressionistic judgment. The nonexpert has been used experimentally when purposes and techniques have provided for increased objectivity and simplification in scoring or when a hypothesis is specifically directed at reliability.

Evaluations by Judges: Procedures and Consistency—

Procedures by which judges evaluate figure drawings are determined largely by whether the drawings are used in experimental or semi-experimental settings or for clinical purposes. The distinction between the two kinds of situations implies lack of over-all standard procedures. The procedure most commonly described for the earlier uses of figure drawings is summed up by Albee and Hamlin:[16, p. 390] "It is our observation that many, if not most, clinicians make judgments and interpretations of patients' drawings with little conscious attention to specific, molecular factors of constant significance, but rather as a result of global impression of unverbalized comparison of a present drawing with past experience of 'intuitive' or insightful impressions."

Procedures of evaluation otherwise vary with the type of rating scale or scoring method identified with a particular study. In some few cases by virtue of the adoption by one investigator of another's system of scoring, identical or similar procedures appear in judging.[24, 33, 40] Levy[5c, p. 258] points out that figure drawings are vulnerable to misuse because there is no complicated system for scoring for judges to master and that for this reason they make "an attractive instrument for the reckless or impulsive individual."

Evaluations of figure drawings as reported in the literature show consistency in some studies between the ratings of judges, and inconsistency in others. Sometimes relationships are expressed in statistical terms and sometimes only in descriptive terms of agreement or disagreement. Statistical comparisons indicating relatively high agreement are reported in eight of the studies examined.[12, 16, 17, 27, 30, 35, 42, 45] The judges were limited to clinical psychologists in all but one of these studies. Steinman[45] designated his judges as psychologists and nonpsychologists and concluded that rankings by opinion or "global impressions" were about equal for the two groups.

Disagreement among judges in a particular study is reported in relatively few of the studies examined for this review. Neither Blum[48] nor Grams and Rinder[34] found consistent agreement among interpretations of judges with Machover's items of assessment and clinical rating scales. Kotkov and Goodman's judges[15, 46] were not in agreement on the predictability of personality traits from figure drawing characteristics. Schmidt and McGowan[20] found wide variation in judgment between individual judges in their analyses of drawings of persons with and without visible physical disabilities. Fisher and Fisher[38] found little agreement among raters—no greater agreement among psychologists with training in figure drawing analysis than among psychiatrists and stenographers. Steinman[45] reported rankings by nonpsychologists using his manual were less consistent and had greater "range and scatter" among themselves than did the rankings by psychologists. Kotkov and Goodman[46, p. 367] concluded that it is likely that "the judges were influenced by different backlogs of experience and employed over-all judgments in arriving at their rankings." Barker, et al.[32] and Mainord,[29] in their studies on homosexuality, were in disagreement with Machover on signs of homosexuality found in drawings. Lakin's findings[21] in a study of disparate age levels were in agreement with those which Machover presents on structural characteristics.

Difference in criteria applied in judging or evaluating some aspects of figure drawings may be illustrated as follows:

Mouth Cramer-Azima[13, p. 146] "and the open mouth suggests greater strength, self confidence, energy and aggression."

Graham[24, p. 385] "and an open mouth, a sign of immature dependency needs."

Accessories Levy[5c, p. 281] Cigarettes, pipes, canes signify "a striving for virility."

Machover[2, p. 82] Pipe, cigarette, gun—manifestation of sexual preoccupation "when given particular emphasis and made active."

Erasures Goodenough[3], p. 90 in the Draw-A-Man Test does not regard erasures as an unfavorable sign in older children even though they detract from the appearance of a drawing.
Machover[2], p. 98 interprets erasures as evidence of anxiety and conflict.

On the whole, the evident general lack of consistency among judges' evaluations is no greater than it is among the purposes for which the Figure Drawing Test is used, and the hypotheses developed for investigation. The often repeated conclusion that "the results warrant further investigation" appears to be justifiable as applying to a study of consistency among evaluations.

Summary—

Among 60 studies examined for this review, claims of demonstrated superiority of any one set of qualifications of judges are not an obvious issue. A large proportion of the studies occur in a clinical milieu and show a pattern of the use of trained, experienced psychologists as judges. This pattern follows that of the original use of the Figure Drawing Test as a projective technique.

In some references cited here strong feelings are evidenced that only the use of the skilled clinical psychologist, trained in interpreting figure drawings, may be sanctioned for making ratings. Insistence from other sources is also strong that scientific respectability must characterize projective psychology and that little progress can be made with the use of the figure drawing as a personality indicator until procedures are sufficiently objective to permit the use of judges who are not specialists in the evaluation of figure drawings.

Obviously no general conclusions can be drawn regarding the consistency of evaluation between judges as shown by these studies. No two studies of those listed were working on the same hypothesis leading to verification or nonverification. No two were tests of similar procedures for standardization in use, development of norms, or any other objective which would warrant generalizations.

Points of disagreement relative to judges and evaluations of the Figure Drawing Test are essentially the same as those which occur with other projective techniques. The controversial problem of evaluation emerges, according to Macfarlane and Tuddenham, out of three different traditions in psychological research: experimental, statistical, and clinical.[47a, pp. 29-30]

3. *Validity and Reliability*

Problems—

Primary criticism of the Figure Drawing Test is aimed at its alleged lack of evidence of validity and reliability. When the terms validity and reliability are so used, they bear the meaning attached to them by the psychometrist who works with nonprojective tests.[47a, pp. 42, 35] The following, summarized from the literature, are some of the reasons why generalizations from the results of the Figure Drawing Test are unwarranted: limited samplings with inadequacy of data; lack of control measures; dependence on wide range of judges with varying experience and degrees of competence; lack of stable, consistently objective criteria for evaluation; and conclusions derived from studies of limited, selected populations not applicable to other populations for verification and prediction.

One psychologist,[5c, pp. 257-258] oriented to the use of projective tests, says: "The clinical psychologist who analyzes drawings is in the challenging situation of arriving at sufficient conclusions from insufficient premises. . . . As for the reliability and validity of judgments based upon drawing analysis, there is inadequate information available. The incomplete and inadequate experimentation in this area by myself and others, however, is promising enough to warrant continued exploration of the merits and limitations of drawing analysis. What is more, the lack of adequate information about validity does not negate the clinical utility of this technique. We are concerned here with a phenomenon that has been skillfully exploited by psychologists in the area of intelligence and aptitude testing where a number of tests, each with a low or undetermined index of validity, when combined with other tests of insufficient validity, yield acceptably valid results."

Abt,[5a, p. 64] in writing of the theory of projective techniques, says: "I am of the belief that projective tests have developed from a climate of opinion so radical and different from that which made possible other personality assessment procedures that their validity and reliability can never be established in the same ways." The Witkin study[6] used graphic measurements and statistical correlations from which both quantitative and qualitative conclusions were derived, thereby demonstrating the handling of both types which Abt[5a] states is essential to the study of personality. Research of the last decade shows a marked trend in the direction

of serious effort to determine whether the Figure Drawing Test can meet validity and reliability requirements in terms which will justify acceptance of generalizations on its diagnostic or predictive value. No one piece of research can be identified solely under the limitations of any one class of techniques. A combination of techniques is likely to be essential to the whole process of validation in any one study. In this review investigations are, for convenience, grouped within arbitrarily chosen categories.

Control and Experimental Groups—

Royal[19] split control and experimental groups in half. Scoring items of an objective graphic nature were used, 18 showing probable differential value when applied to the first halves of the groups. The 18 were reduced to eight, which were combined into a scale for use with the second halves. A scale made up from points in combination was found to be more significant than points used individually in scoring.* The author reported a tendency toward statistical significance on the frequency of appearance of the scale items in both halves of the experimental group of neurotic patients as compared with the control group.

Holzberg and Wexler reported on a study which sought (a) to test the validity of human form drawings as a personality instrument and (b) to provide a basis for an objective analysis of drawings. An experimental group and a control group were used in an effort to determine the validity of figure drawings as differentiating instruments.** The authors reported significant differences on the over-all results between normal and schizophrenic subjects. Items were considered significant only if they fell at the 5 per cent level of confidence or better. Two years later the same investigators,[36] using a new population for study, attempted to discover if the items found significant in their previous study would again discriminate with statistical significance between normal and schizophrenic subjects. The authors reported successful discrimination between normal and schizophrenic subjects at the 1 per cent level of significance, but less reliable discrimination between normal and a subgroup of paranoid subjects.

Reznikoff and Tomblen[18] investigated the reliability of 17 graphic indicators set up as criteria for the diagnosis of organicity, and for the degree to which the indicators distinguished between or-

*cf. Part II, 2. "Methodology," etc.

**cf. Part II, 1. "Differentiation."

ganic patients and other psychiatric groups. The χ^2 method was used for comparing three groups: organic, neurotic, and schizophrenic. The investigator found five of 14 indicators more characteristic of the organic group than of either of the other groups but concluded that seven of 11 indicators must be present to establish the correctness of a diagnosis of organicity as differentiated from neurosis or schizophrenia.

Kosseff[14] used an experimental group and a control group in a study to determine if there was any relatedness between changes in body image of the subject as reflected in figure drawings and changes in the subject during psychotherapy. The author reported a better-than-chance relationship between the changes in the figure drawings and the changes which took place under psychotherapy.

Kotkov and Goodman[15, p. 364] divided their subjects, 101 obese and ideal-weight women, into pilot and experimental groups, matched for age, educational level, intelligence, marital and employment status. The pilot group consisted of 25 obese and 20 ideal-weight women; the experimental group, of 36 obese and 20 ideal-weight. Forty-three graphic structural items were set up for analysis of the figure drawings. From these, 32 were found to be significant at a 2 per cent or better level on 129 χ^2 tests. Of the 32 applied to the experimental group, seven were found significant at a 5 per cent or better level in differentiating between two experimental groups. The authors found inconsistencies in their results which led them to suggest that a "more Gestalt approach to the drawings may be fruitful."

The suggestion that dynamic personality principles operated to determine differences between groups led to a further effort to equate personality traits with a specific measure of the drawings. The predictions based on certain assumptions regarding personality traits were not supported by the findings.

Comparison With Other Criteria—

Davidson,[28] in an unpublished thesis, studied the possibility that cultural differences might represent a criterion for discriminating between characteristics of human figure drawings. Four groups of children were used, 50 of each of two races in two different cultural environments. From a check list of 125 characteristics appearing in the drawings, a total of 23 was found to be significant for differentiating between the groups, based upon frequency of

occurrence. Two drawings by each child were evaluated independently by three judges. No statistical evidence of validity was presented by the author.

Lakin[21, p. 473] compared drawings of 24 institutionalized aged subjects with those of 25 normal children in the third grade of school. Central variables of self-conceptualization and body image, reflected in area, height, and centeredness of drawings on a sheet of paper, constituted the basic criteria for judgment of the drawings. Statistical calculations were made from specific measurements in inches. The author reported statistically significant evidence for the validity of his assumption that formal aspects of human figure drawings are related "to central variables of self-conceptualization" and "that children seem to perform more similarly to normal adults than do the aged," who produced "more constricted, shorter, and less adequately centered figures."

Machover's[2] interpretations of characteristics of figure drawings provide the criteria by which various investigators seek to demonstrate validity of interpretation. Mainord[29] proposed a hypothesis that drawing the opposite sex first was a possible sign of sexual inversion. She relied on the Machover system for judgment of the drawings, and arrived at a somewhat ambiguous conclusion that her data, reported in percentages, suggest validity for drawings of the male subjects but not for female subjects.

Blum[48, p. 125] compared ratings by: (1) psychiatrists, (2) a battery of psychological tests, and (3) psychologists' "own impressionistic technique," with ratings of figure drawings of 31 neuropsychiatric patients by the Machover system. He reported there were "no significant agreements of the Machover Draw-A-Person with any of these clinical procedures or 'standards' nor were there any significant agreements of the intuitive approach to Draw-A-Person interpretation with any of these clinical rating scales."

Steinman[45] designed a study to determine the validity of the figure drawing as a measurement of intensity in psychosis by correlation with a known physiological criterion of severity in mental illness. Thirty-seven male and 29 female hospitalized and ambulatory patients of a mental hospital were the subjects. Two groups of judges, psychologists and nonpsychologists, made two sets of ratings of the figure drawings, the first of these based on unrestricted opinion. For the second, a manual, made up of 59 items empirically derived from the drawings, was used, and a

numerical value was assigned to each item. The drawings were rank-evaluated for intensity of psychosis. This ranking was compared with the known intensity of psychosis as measured by the patient's histamine tolerance. Steinman reported that opinion rankings "of the drawings in Group I by the four judges correlated significantly (at the 1 per cent level of confidence) with the ranks of relative intensity in psychosis established by histamine tolerance. There was no significant difference between the abilities of the psychologists and the non-psychologists... When the Manual was used to rate drawings... other than those from which it was derived, the results were significantly better than opinion correlations. The psychologists surpassed the non-psychologists in a significant manner."[45, pp. 2-3] The author concluded that the manual, cross-validated by 12 judges, is efficient and valid and that validity of the Figure Drawing Test was confirmed for the purposes of his study.

Graham[40, pp. 372-378] reversed the order of Steinman's study and used the manual as the criterion base for predicting an estimated histamine tolerance. For validation, the estimated histamine tolerance as predicted through the use of the manual with figure drawings, was correlated with actual tolerance. The correlations of .702 between figure drawings and actual histamine tolerance data was significant at the .004 level of confidence with a predictive efficiency only .29 above chance. The author stated that while the "results of this investigation show the Steinman Manual to be a relatively ineffective clinical measure, the assumption that human figure drawings are closely related to physiological reaction patterns is substantiated." Previous studies had demonstrated that separation of certain psychiatric groups by histamine tolerance was possible.

The results in the Witkin study[6, pp. 247, 457, 458] of the use of a short scale of graphic items in the scoring of the Figure Drawing Test present correlations between subcategories of the scores and perceptual test subscores. High positive statistical correlations are reported as confirmation of "the working hypothesis on which the choice of drawing items was based." These correlations supported the conclusion that the drawings revealed certain personality trends which are discussed in detail in the report. For college students, "The correlations among the three primary techniques (interview, Rorschach, and Figure Drawing) are fairly high, and all of

them are significant at or below the 1 per cent level of confidence." The author refers to another earlier study, made by other investigators, in which low correlations were found. He suggests that the differences between results of the two studies are due to difference in definitions of the variables, and that "in studies of the relation between personality structure and other characteristics of the individual, clear definition of these characteristics makes it more likely that relationships, if they exist, will become evident, and consequently that findings about the same person obtained through different personality tests will be in agreement." The Figure Drawing Test showed higher correlations with the interview and with the "coping scores" of the Rorschach than with the "introspective scores" of the Rorschach. The author considers the high correlations found to be evidence of the validity of the three personality techniques used.

Swensen's analysis of research on the use of the figure drawing[52, p. 462] is focused particularly on the Machover hypothesis. He pointed out that experimental evidence does not support her hypotheses, but also that "few of the studies reported were designed to test the specific hypotheses of Machover's."

Separate Ratings—

A study designed specifically as a reliability test was reported by Lehner and Gunderson.[42] The investigators devised a rating scale with 21 graphic traits or variables, each trait described by a set of mutually exclusive descriptive terms. Figure drawings were made by 91 psychology students, and a plan for judging was set up to test the consistency of the variables of the rating scale. Ratings were divided as follows: (1) ratings and reratings by the authors; (2) ratings by other judges; (3) ratings by the authors on a second administration of the test four months later. The degree of agreement among ratings was expressed in percentages as follows:

	Per cent
All ratings on first and second testing	64.1
Ratings and reratings by the authors	90.5
Ratings of other judges and the authors	83.4

The authors concluded that relatively high consistency in ratings may be obtained if an objective and explicitly formulated rating system is used. They found that the relatively high degree of

constancy of traits was to be found in content aspects of drawings, as well as in formal aspects, and they indicated need for further study of validity and reliability applied to interpretations based on the indices in the results of this study.

Blum[48] also used ratings by different judges in his study of validity of the Machover system. This is a study in clinical agreement with a rating scale made up of interpretations condensed into personality characteristics, in contrast to the Lehner-Gunderson graphic scale. As previously stated, Blum found no clinical validity as measured by his study. For the two items which he considered most likely to show agreement in all ratings—anxiety, and problems in handling aggression—agreement was not statistically significant.

Swensen,[27] in a study of sex differentiation as reflected in figure drawings, used two judges working independently. Ratings of the two judges, made through the use of a five-point continuum scale for a comparison evaluation on 58 sets of drawings, selected at random from a file, resulted in a .84 correlation, which Swensen claimed as his scale reliability.

Albee and Hamlin[16, p. 391] made an investigation specifically for the purpose of testing the reliability and validity of global or insightful impressions of figure drawings, using a paired comparison evaluation technique. Following recommended statistical procedures, they used a split group plan for determining reliability and obtained the mean preferences for each group of judges. Mean preferences were converted into scale values, with a constant added, and a linear correlation computed between the two groups of judges. The authors found the linear correlation to be .955 which with the Spearman-Brown formula became .977. From the rank order correlation between figure drawings and case records in their validity test, the authors concluded: "it appears that clinical psychologists can make reliable judgments of 'global adjustment' from drawings-of-a-man-and-a-woman," with also "... rather convincing evidence that the judgments of adjustment determined from drawings agree with the adjustment of the subjects determined by the case records." Two years later, the same authors[17] reported on a follow-up study using the same procedures. Reliability of ratings by four judges on the split group plan was reported as .89, significant at the 1 per cent level of confidence. Validity dependent on the efficacy of the criterion scale for differ-

entiating between the levels of adjustment of two groups was indicated by critical ratios: between normal and neurotic—5.56; between normal and schizophrenic—3.68, significant at the 1 per cent level; no significant difference between neurotic and schizophrenic cases. Six years later with a different hypothesis and different criteria and methods, Reznikoff and Tomblen[18] reached the same conclusion regarding neurotic and schizophrenic differentiation.

Both the Blum[48] and the Albee and Hamlin[16, 17] studies were directed at insightful impressions by clinical psychologists. With different approaches and procedures, the two investigations produced contradictory conclusions on the validity of figure drawings for measuring adjustment levels of emotionally or mentally disturbed patients. However, each investigator stressed that his conclusions were made only within the limitations of his study. Albee and Hamlin[16] translated personality attributes into graphic indicators for global ratings, whereas Blum[48] retained personality items for his three-point continuum rating scale.

Schmidt and McGowan,[20] in a differentiation study, reported the results of separate groups of judges in terms of χ^2 findings: (a) that differentiations were apparent between the drawings of the two groups of subjects of which one-half had visible physical disabilities, one-half had none; (b) that there was no demonstrable superiority of any one group of judges in regard to drawing judgment; and (c) that there was wide variation in judgment between individual judges.

The Berman and Laffal work[12] is illustrative of the range of variables to be found in use in efforts to determine the validity of figure drawings. A three-category scale of body type was used for rating, in a comparison study between the body type of the subject and the figure drawing made by him. For validity of judgments, clothed subjects were checked against 11 nude photographs, full face and profile, with a resulting Pearson correlation coefficient of .73. Drawings were judged first by one of the two authors after key numbers had been substituted for identifying names. After three months, the drawings were again rated, but by the other author. Agreement was found on 39 of the 52 drawings inspected. A Pearson correlation coefficient of .35 was computed, significant between the .05 and .01 levels. The authors con-

sidered that their findings supported their hypothesis on the relationship between figure drawing and body image.

Retest—

Three of the research investigations examined have used a second administration of the Figure Drawing Test to the same subjects as a check on the reliability of the measure; two placed a time interval between the two tests. Starr and Marcuse[25, p. 86] injected another factor than that of the time element into their reliability study. They proposed to determine the effect on reliability of different examiners as well as of time interval between administrations of the test. The subjects, 193 college students, were divided into three groups. For two groups, the test was administered a second time after an interval of one month. For one group, the same examiner was used both times and for the other group, a different examiner. For the third group, the second administration of the test followed immediately after the first and with the same examiner. Seven easily scored graphic items were used in rating the drawings. The investigators concluded that a change in examiners was not important and that the time interval was without effect. Five of the seven factors used in rating were found to be reliable for both sexes, one unreliable for both, and one reliable for men only. The authors stated that "the lack of reliability in a projective test does not exclude the possibility of validity" but that "the presence of reliability in some factors makes the study of validity more encouraging."

Graham's study[24] on reliability of the Draw-A-Person Test used the Steinman Manual as a scoring instrument. Twenty-three college students with no orientation to the use of the figure drawing as a projective technique were asked to draw the picture of a person. Immediately afterward, they were given a two-hour lecture on the negative interpretation possible for each item of the Steinman Manual.[45] The subjects were then asked to make drawings in the same manner as before. The means on the scores of the two sets of drawings were 2.1 and 2.2 respectively and the difference was regarded as insignificant. The t test evaluation of the means of the two sets of drawings was 3.33. The correlation between paired sets of scores was found to be .71 at better than the 1 per cent level of significance. The author concluded that for the majority of subjects there was little or no change

in the second drawing and that where radical changes were attempted, no subject improved his production.

SUMMARY

Of the studies appearing in the last decade, 10 of the 60 examined for this review are primarily concerned with the specific purpose of testing the validity and reliability of the Figure Drawing Test. Twenty more have made the test of validity and reliability concomitantly specific with the test of a stated hypothesis. An additional 10 have stressed the two qualities in the handling of data derived in the investigation of a hypothesis. Thus, approximately two-thirds of the research reports included in this review have been concerned with demonstrating the validity and reliability of the Figure Drawing Test as expressed in statistical terms.

The one result of the various studies on validity and reliability of the Draw-A-Person Test which approaches the status of a generalization is the often reiterated statement that the findings indicate need for further research, or that further research on validity and reliability is warranted. There is a strong tendency in the direction of the use of graphic items as a guarantee of greater objectivity in rating and as a basis for producing statistical evidence of validity and reliability.

A question readily arising from a review of studies made is: For what kind of validity are investigators searching? Many studies seem to have related validity to one specific concept, different in major degree from concepts of other studies or with widely different variables. Macfarlane and Tuddenham[47a, p. 46] state that:

> One of the major troubles to date in validation studies has been that a large unexplicit set of validation objectives has been sought simultaneously without regard for the fact that each objective has to have explicit formulation to be testable, and that each has to be tested against its own relevant and reliable criterion.

Witkin[6, p. 473] maintains that the Figure Drawing Test "provides a particularly direct indication of the individual's self-concept." Under an umbrella of body image or self-concept, subcategories may be defined. The Witkin study has done this in a manner different from any other study. It has been pointed out previously that authors working specifically in the area of body image and personality regard the Witkin study as a particularly important contribution.*

*Cf. Part II, 1. "Differentiation."

Part III—Interpretations

Interpretations of the Draw-A-Person Test, like validity, are closely linked with the particular purpose for which the test is used. Major generalizations are seldom presented. When generalizations do appear in the literature, they are more likely to be derived from theory than from tested hypotheses. Recommendations most frequently occurring are that continued or repeated use of a given technique is warranted or that more research is needed before conclusive evidence can be claimed.

Interpretations in general fall into two classes: qualitative or clinical, and quantitative. Within these two categories, analyses may be further classified as "content" and "formal" with the two supplementing each other. Formal analysis is described as a method of setting up factors which can be quantified and which rest "ultimately upon the assumption that statements made about an individual subjected to the test will possess greater precision if they are stated in mathematical terms."[75a, p. 40] Content analysis is symbolic in nature and is essentially different from interpretation in terms of structural characteristics as defined by the same author.[5a, p. 40] Hypotheses formulated for the use of figure drawings are frequently focused around general objectives related to classification of interpretations of figure drawings.

1. *Prediction*

Machover's system of evaluation includes a list of drawing characteristics, chiefly content, which she considers indicative of homosexuality. Several investigators have attempted to determine the validity of these characteristics as predictors. The following investigators failed to establish predictive significance of the Machover system of evaluation: Grams and Rinder;[34] Barker, Mathis and Powers;[32] Mainord;[29] and DeMartino.[33]

Kotkov and Goodman[15, p. 367] concluded that predictions based on certain assumptions regarding personality traits of obese women were not borne out in the findings of their study. They state:

> It would seem important that further research be directed at the definition of various types of interpretive schemes, that some attempt be made at evaluating them and increasing their effectiveness. The distinction between "form" and "content" interpretation is an ingenious discovery that has been applied to other projective techniques; it may become a useful and important development in the interpretation of the Draw-A-Person Test.

In his study of the relationship between histamine tolerance, psychological states, and certain aspects of perception, Graham[40, p. 873] found a significant relationship between histamine tolerance and figure drawings of patients but concluded that the predictive efficiency was not high enough for use in estimating histamine tolerance. However, he believed that his results warranted an assumption that figure drawings are closely related to physiological reaction patterns.

Fisher and Fisher[39] concluded that sexual differentiation in figure drawings of emotionally disturbed women was meaningful and predictive of sexual adjustment and general personality integration.

2. *Differentiation and Diagnosis*

Interpretations of differentiation obviously arise when control and experimental groups are used. Though often a part of diagnostic studies, differentiation is not limited to diagnosis. In their two studies reported in 1949 and 1950, Albee and Hamlin[16, 17] found their method effective in differentiating two groups of neuropsychiatric out-patients from normal subjects. They state that "the degree to which an interpretation of a drawing is derived from its specific elements or from intuitive impressions of the judges is not clear. Presumably, interpretation depends on specific elements and their synthesis."[16, p. 389]

Holzberg and Wexler,[46] in their two studies, concluded that an analysis of figure drawings can be statistically evaluated with success for differentiating between normal persons and schizophrenics.

Reznikoff and Tomblen[18] did not establish enough significant indicators for diagnostic purposes. They concluded that their method and its results had limitations for diagnosis but provided a basis for further investigation.* Royal[19] claimed a tendency toward significance for differentiation between anxious neurotic patients and control subjects free from overt anxiety symptoms.

Steinman[45, p. 66] concluded that a significant correlation exists between the rank order of figure drawings of patients and the "ordinal positions established by a physiological criterion of levels of intensity in psychosis: e.g. histamine tolerance." The author does not go far enough to recommend from his findings that the

*Cf. Part II, 1, 3. "Differentiation" and "Validity and Reliability."

Figure Drawing Test be used for the diagnosis of level of intensity in psychosis.

Schmidt and McGowan[20, p. 183] set up the hypothesis that figure drawings made by physically disabled persons can be differentiated from those made by normal persons. The investigators concluded that "figure drawings really are projections of the drawer, but not merely as simple projections of self-image."

Swensen[27] defined sexual differentiation in figure drawings as the degree to which an individual correctly identifies himself sexually. As a corollary, he assumed that clear and correct differentiation is an indication of maturity of sexual identification and of unimpairment. He concluded that hospitalized mental patients have significantly lower sex differentiation on the Draw-A-Person Test than do patients treated in the out-patient clinic, but pointed out the need for more extensive norms from a large number of normal individuals. The data of the Witkin study[6, p. 365] suggest a difference between hospitalized men and women with respect to problems with which they are concerned. The scores on drawings evaluated by the graphic scale reflect greater frequency for men in problems of "sexual identity," whereas women are more often concerned "at a more primitive level of self-differentiation and personality development," indicated as "separate identity."

The high correlations found in the Witkin study[6, p. 254] between figure drawings and other measures of personality characteristics were considered evidence that distinctions between "field-dependent" and "field-independent" characteristics of subjects may be deduced from analyses of figure drawings:

> In general the results show that persons who are field dependent in their perception produce figure drawings reflecting a low evaluation of their bodies, infantile defenses against anxiety, lack of self-assurance, passivity coupled with uncontrolled expression of hostility, and difficulty in accepting an adult role. On the other hand, people who are not influenced by the prevailing field and who are capable of dealing with it in an active, analytical fashion produce drawings expressing a high degree of narcissistic investment in the body, sophisticated defenses against anxiety, self-assurance, identification with "desirable characteristics" of both sexes, strong drive, and manipulative tendencies in controlling their drives.

Differences in distributions of drawing scores of men and women led to the observation that "males who tended to be analytical in perception and to remain independent of the field produced

drawings that reflected less stress than the drawings of females with the same kind of perception."[6, p. 252]

Goodenough[3, p. 60] noted, in analyses of the Draw-A-Man Test, that there were differences, particularly sex differences, of a qualitative nature which indicated the possibility that characteristics other than intelligence were reflected in the drawings. The author identified these differences with individual interests and personality traits rather than with the possibility of existing mental disorders. Differences between the sexes were sometimes attributed to greater docility and more studious habits on the part of girls. Striking differences in line with what might "correspond to relative interests and abilities of boys and girls" were shown in a random selection of drawings from "ten different localities representing a wide range of social status and racial stock." Goodenough saw in these differences potential meanings extending beyond the evaluation of intelligence.

3. *Self-Identification*

Self-identification is closely linked with the body-image concept in the literature of figure drawings. Variables to be found in studies under this category include unusual physical and psychological conditions, age, and cultural milieu. Berman and Laffal,[12, p. 370] as a result of their findings from a body-type and figure-drawing study, concluded:

> In the common meaning of projection as applied to clinical tests, figure drawings are thus seen to reflect certain concrete aspects of the person drawing the figure. The psychological implications of the parallelism between body type and body type drawn are not entirely clear. The parallelism may indicate that individuals when given free rein to draw a figure, draw one they are most familiar with, their own. The findings also tend to support the hypothesis that the figure drawing represents, at least in part, a projection of the body image.

In a longitudinal series of figure drawings Cramer-Azima[13] saw a measure of a patient's progress or relapse during therapy. Kosseff's[14] investigation produced a conclusion somewhat similar.

Holzberg and Wexler, in their differentiation study, claimed verification of the assumption that human form drawings reflect personality characteristics, those elements of personality which are significant to the individual. The assumption was derived from various other studies of the uses of figure drawings and from the work of Goodenough[3, p. 76] in particular. Goodenough con-

cluded: "It is evident that the child does not show in his drawing all the facts which he knows about the object, but only those which to him are so essential or characteristic that they occur to him spontaneously without suggestion from outside sources." Holzberg and Wexler[p. 347] cite this conclusion as applicable to the drawing of the human figure.

Kotkov and Goodman,[15] though finding no predictive value for personality qualities in their study of obese women, reported that the figure drawing of their subjects reflected perception of the female figure, their own, as a measure of differentiation between obese and ideal-weight women. The conclusion made by Schmidt and McGowan[20] is an illustration of the close link between interpretations of differentiation and of self-identification. Those qualities of drawings which differentiated between visibly physically disabled persons and persons without visible physical disabilities were interpreted as identifying the self of the person making the drawing.

Modell and Potter[50, p. 292] used the figure drawing as a device for studying the personality characteristics and conflict problems of hypertensive patients and those with peptic ulcer and bronchial asthma. The Machover clinical technique for analysis was used. The drawings obtained over a considerable time from the same individual showed remarkable self-consistency, according to the authors, who point out also that interpretations from the drawings have not been experimentally verified. They concluded that the drawing features of the hypertensive group "emphasized inner contradictions and obvious inconsistencies in personality organization," that patients tended to "depict themselves as weakened, depleted, inadequate individuals" and gave evidence in the drawings of a need for personal assertiveness. The investigators further concluded that the Figure Drawing Test is suited to psychosomatic studies and that its use should be encouraged both in research and for therapy in the field of psychiatry.

Several investigators directed their hypotheses toward age relationships and characteristics evidenced in figure drawings as a part of self-identification. Lakin,[21] in his comparison of the drawings of children and of aged adults, found evidence that a body-image characteristic of age is reflected in figure drawings. Lehner and Silver,[22, p. 207] from a study of age relationships in normal subjects, concluded:

The high consistency in the way in which each sex draws both figures would seem to indicate, among other things, that each sex "projects" itself in a characteristic and consistent manner into both the male and the female figures drawn.

The same study also claimed the reflection of a cultural emphasis in the age characteristics and descriptions of the drawings: that women beyond 35 show a progressively greater retreat to younger ages for figures drawn; and that men up to 25 advance the age beyond their own but after 25 characterize it as progressively lower. The result of the application of a graphic scale to the figure drawings of children in the Witkin study[6] showed an increase in maturity of self-concept between the ages of eight and 13 toward greater growth and differentiation of the self-image. Lorge, Tuckman, and Dunn[23] made a comparison of self-drawings of graduate students and of adults aged 60-90. The investigators concluded that figure drawings might be used to provide evidence of physiological and psychological adjustment. The drawings made by older people in general were characterized by poor motor co-ordination, bizarreness, incompleteness, and lack of integration and of proportion.

Implications of the effect of cultural influences on self-identification are reflected in the findings of three other studies. Davidson's use of figure drawings[28] in a study specifically directed toward cultural differences has already been cited.* Mainord[29, p. 189] states that "the fact that a large proportion of females might draw the male figure first may reflect recognition that the role of the male has many advantages not afforded their own sex." An earlier reference to conclusions drawn in the Witkin study[6, p. 252] pointed to the identification of certain drawing characteristics with other criteria associated with field dependence or independence. The interpretation was made that the difference in field dependence between men and women may quite possibly reflect the male role in the environment—self-determination and independence of the field—"whereas women whose personalities lean in that direction meet with greater opposition from the environment." These findings denoting possibility of cultural influence in sex differentiation of figure drawings are consistent with Anastasi's résumé of the effect of cultural factors on sex roles and sex differences in West-

*Cf. Part II, 3. "Self-identification."

ern society, which "may reflect in part the prestige and other advantages associated with the masculine role in our culture."[28, p. 470]

Graham's study[24, p. 385] of the effect on the drawings of graduate students made before and after they had received information on the possible negative interpretations to be made from figure drawings referred to interpretive conclusions of other investigators:

1. Workers in the field agree that drawings depict the body image and the self-image.[12, 45]

2. Fundamental personality traits as reflected in human figure drawings do not vary appreciably.[37, 42, 58]

3. Changes such as aging contribute to the basic structure of personality and are reflected in recognizable elements of the drawing.[22] Graham's conclusion on self-consistency has already been cited.*

Swensen's conclusion,[27] that clear and correct differentiation in figure drawings is an indicator of maturity of sexual identification and of unimpairment of the individual, is related to the theory of self-conceptualization.

Ponzo[59] used a totally different approach for administering the Figure Drawing Test and arrived at a conclusion within the range of the self-image concept. The first drawings made by his subjects were done according to conventional procedures. For the second set, the subjects were asked to draw the human figure as an idiot would. Changes in characteristics included simplification, exaggeration of sexual and aggressive details, and an "expressive style." Ponzo concluded that these changes suggest "disinhibition," revealing aspects of personality previously concealed.

The Witkin study[6, p. 469] summarizes personality characteristics related to the various aspects of the study under three headings. One of these is the individual's concept of self or his self-evaluation. Two extremes are defined:

> The one associated with field-dependent behavior involves low self-esteem, difficulty in accepting oneself, and low evaluation of one's body. The other trend, related to analytical perceptual behavior, involves high self-esteem, self-acceptance, and confidence in the body. Differences in self-evaluation were clearly expressed in the Figure Drawings, which at one extreme reflected a relatively undifferentiated and primitive body image and at the other an integrated, more adult conception of the body.

*Cf. Part II, 3. "Self-identification."

Fisher and Cleveland[7, p. 35] summarize as follows their survey of conclusions on figure drawings as related to the concept of body image cited in the literature:

> By and large, one gets the impression that although the figure drawing may be a potentially valuable method for studying body image, it has as yet not added much to our knowledge in this area. It is still mainly used in a vague impressionistic manner and there has been limited success in differentiating which aspects of the drawing are linked with body image, which with drawing skill, and which are due to the manner in which the drawing is obtained.

On the other hand, the same authors refer specifically to the value of the Witkin study, noting Machover's contribution to it:

> Machover was able to devise a technique for rating figure drawings which correlated very significantly with the degree of field dependence versus independence of field shown by the subjects. . . . Machover concluded on the basis of her data that an individual's attitude toward his body has a significant influence upon his ability to deal with unstructured spatial situations. . . . This study . . . demonstrates in a convincing fashion that body image is an important variable in a primary area of perceptual functioning.[7, p. 34]

4. *Artistic vs. Projective Significance*

Woods and Cook[57] proposed a hypothesis that proficiency in drawing rather than personality characteristics is responsible for placement of the hands in the Figure Drawing Test. Evaluations by artists and by M. A. candidates in clinical psychology were made by the paired comparison method, and the drawings were classified on a proficiency scale. The authors concluded that personality interpretations are limited, and that variance in drawings is to be attributed to structural quality as distinct from symbolic personality characteristics.

Feldman and Hunt[55] were even more positive regarding drawing proficiency. They stated that body parts most difficult to draw are most often rated by clinicians as indicators of emotional disturbance. Whitmyre[11] and Sherman[9, 10] made similar interpretations in their respective studies on the influence of artistic quality on the judgments of figure drawings. Buck[1] stated in relation to the interpretation of scoring on the House-Tree-Person Test that an item may lend itself to different interpretations. As an illustration, the hands-in-the-pocket item may indicate avoidance of the difficulty of drawing hands as well as symbolize anxiety.

Holzberg and Wexler cited validation studies reported by Waehner[60] and by Goodenough[3] in support of a premise that figure drawings are not influenced by school instruction or manual skill. Goodenough,[3] in validation tests, had children who were in the process of having instruction on drawing the human figure according to a set pattern given the Draw-A-Man Test, first by the person instructing in the drawing and later by someone other than the drawing teacher. In the second test, many of the children reverted to the type of drawing considered characteristic of their age level. It was found also that little or no effect of drawing instruction from the first grade was evidenced in drawings made in second and third grades by the same children.

SUMMARY*

To a great extent interpretations are centered about problems concerned with clinical analysis of mentally or emotionally disturbed patients, populations limited in their possibilities for producing generalizations beyond the scope of psychodynamics or psychodiagnosis. Twenty-eight of 46 studies using specific hypotheses had mentally disturbed individuals as subjects. Thirteen used persons without overt evidence of disturbance, or persons identified as normal. Several studies used both, when control and experimental groups were compared. Four studies were specifically directed to physiological factors related to psychological or personality factors. Of these, three used mentally disturbed individuals as subjects. Even though Machover's use of the Draw-A-Person Test originated historically in a thesis that mental disorders might be reflected in drawings,[2] published studies of the last decade show a tendency toward extending its use beyond a study of mental disorders into a more general range of personality assessment, consonant with Goodenough's observations.[3, p. 60]

In the findings of research studies, prediction, differentiation, and diagnosis overlap. Use of the figure drawing for prediction or diagnosis is still a matter for further investigation. The only study thus far basing its interpretations upon a large number of cases appears to be Machover's. Her comparison of figure drawings with case studies is limited to interpretive synthesis and is lacking in the commonly accepted procedures of scientific research. Enough research has been done to encourage further exploration of the possibility that the figure drawing reflects physiological

*Summary of Part III. "Interpretations."

and psychological change, as well as a relationship between the two, for use in prediction and diagnosis.

Ten studies have shown some efficacy of the figure drawing in reflecting differentiations of one kind or another between subjects or groups of subjects. The clearest evidence of a differentiating value of the figure drawing appears in its high correlation with other measures which distinguish "field-dependent" personality characteristics from "field-independent" characteristics.[6] Differentiations most significantly indicated were between normal persons and those with mental deterioration; children or young adults and aged persons; persons designated as field-dependent and field-independent.

Various kinds of evidence of self-identification in different forms in 16 different studies suggest some merit in the use of the figure drawing for personality assessment, but this, too, leaves questions unanswered. The danger of oversimplification is pointed out again and again in relation to methods of arriving at interpretations. The clinical psychologist insists that there must be "integration of many aspects of the figure" for interpretation of its meaning. He is concerned with the complexities of interaction and is disturbed over the thought of abstracting a variable for setting up a control situation. At the present stage of research developments, the Draw-A-Person Test, used as an assessment technique *with* other forms of personality measures,[6, p. 457] seems to be the most promising means of deriving interpretations that yield sound generalizations.

Judged by the literature on the subject, it seems that widespread use of the Draw-A-Person Test as a measure of personality must wait on standardization of scientifically acceptable procedures. However, in view of some tendency toward its use with normal subjects and of the accumulation of some significant data relative to personality appraisal, it is rather generally conceded that continued experimental work in a wide variety of uses of figure drawings is warranted.

Conclusion

This review of the figure drawing literature from 1949 through 1959 indicates an expanding interest in the use of the Draw-A-Person Test, with increasing emphasis on its role as a research tool. As yet there is no universally accepted scoring procedure,

although many investigators have devised their own scoring classifications.

The major study of Witkin and his associates has demonstrated, better than any other, that reliable scoring can be achieved and that statistically significant correlations can be made between scores for drawings and other test scores, such as those of the Rorschach Test. Accordingly, the authors believe that the Draw-A-Person Test offers promise of becoming a simple, effective, psychological screening device for the personality appraisal of normal subjects.

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AN ANALYTIC INVENTORY OF THE SKILLS OF SOCIAL WORKERS IN THE REHABILITATION OF MENTAL PATIENTS

BY JOHN J. HORWITZ, M.S.

If they are to discharge their professional responsibilities fully, social workers in mental hospitals have tasks to perform in relation to four different groups of people: (1) patients and ex-patients, (2) families and the personal circles of the mentally ill, (3) the community at large and people in key institutions such as businesses, churches and welfare agencies, and (4) the mental health team of the hospital (both professional and non-professional personnel).

Social work activities appropriate to service with all four population groups (the mentally ill, their personal circles, their communities, their therapeutic teams) demand consistent employment of substantially similar skills. When one progresses in inventory from one population to another, shifts in focus and in emphasis will be readily apparent, yet certain prime concerns and basic points of departure are generally applicable. And many of the activities listed require practitioners to engage two or more populations simultaneously.

The most logical point of departure for an analytic schema would be an examination of social work tasks in the very beginning. This, conceivably, is the employment of professional skills in keeping people from becoming mental hospital patients at all. Unfortunately, little emphasis has been placed upon the perfection of prophylactic techniques in social work in the past 40 years or so. The so-called mental hygiene movement has been more preoccupied with assisting the maladjusted, the unhappy, and the ineffective, than with preventing maladjustment, unhappiness and inefficiency in living.

Perhaps, then, it may prove fruitful to analyze the later aspects of the rehabilitation process, taking as a starting point services to a person who has left the hospital. To the social worker, such a person should no longer be regarded as a patient, since he must be thought of now in an essentially extramedical frame of reference. For the benefit of physicians whose conception of the reponsibilities of the mental health team may be essentially similar to the author's, this might be amended to read "the ex-patient

must now be regarded in a broader frame of reference, including the medical, but transcending it."

First, before the patient becomes an ex-patient, the hospital team may need someone to help his family understand both his sickness and his recovery; the social worker is likely to be the person called upon to smooth out some of the rough spots.

Second, help in clarifying the nature of everyday problems to which an individual may address himself may be needed; it could be provided by the social worker. (A significant aspect of the social worker's skill is that he understands the difference between helping by clarifying the nature of the problem, and actually stepping in to solve a problem which should be the ex-patient's learning experience, the ex-patient's hallmark of integrity and independence.)

Third, a person who has been isolated in the very special way of life of a mental hospital for years (or even only for months) may need some rehearsal of approaches to acquaintances he will be meeting anew as if he were returning from a long visit in a foreign land; he may need some coaching before presenting himself for employment. And the coach may be a social worker.

Fourth, the recently ill, possibly convalescent, individual may be hesitant in approaching influential persons who he feels, are a part of another world: for example, placement and counseling personnel at the state employment service, the public welfare worker, the school teacher, even the pastor. The social worker can be the one who paves the way.

Fifth, the person who is again taking a larger measure of responsibility for the direction of his own affairs may find that there are some very crucial matters about which he is ignorant (or facts he has forgotten), and he may be shy about asking too many questions. The social worker is hardly the fount of all wisdom, but he may happily be well informed, readily acceptable and a sufficiently persevering pedagogue to prove helpful.

Sixth, the person once again undertaking to shoulder his family and community responsibilities (or some part of these) may know moments of panic; he may need a measure of continuous, albeit diminishing, support; he may need assurance that an everyday crisis does not necessarily presage a relapse. And through a professionally-cultivated, planfully-implemented relationship, the so-

cial worker may be the one who sees the ex-patient through a day when, like so many of us, he is "all thumbs."

The question may very properly be raised as to whether the social worker should shoulder all of this load, or whether whatever load the hospital carries should be shared among practitioners in several disciplines. To contend that the social worker is capable of performing certain tasks by no means implies that they cannot appropriately be assigned to others similarly qualified—others who are experts in fields relevant to those problems and who have distinctive skills and resources which can be brought to bear.*

The six kinds of help that the social worker can provide for ex-patients come into play in a dizzying catalogue of potentially problematic areas of social engagement and social function. The objective of service will always be to enable the person who is helped to enlarge his own spectrum of competencies and to come to grips with life's eventualities, employing a hopefully growing, problem-solving potential. For one man, a way of approaching selection of the day's necktie may prove a boon; another worries about the larger problem of budgeting for a household and reserving his own pocket-money. One woman wonders whether she can make a go of it again in her church sodality, another is upset because on Monday the sheets don't come out white enough. One person is concerned about warding off effusive Uncle Willie without getting into a fight; another believes that his 15-year-old daughter won't ever bring a friend into the parlor again.

The mention of these potential trouble spots leads to the second population group with whom the social worker is involved. Services to individuals cannot be divorced from services to families. In a home, sleeping arrangements, for example, are rarely the concern of the ex-patient alone. Budgeting, too, is a family as well as a personal problem. Little matters like scheduling TV wrestling matches versus movies, sometimes turn a household into an armed camp. Families can often provide crucial psychic

*A good case can be made for extending carefully selected follow-up services at the hospital to include the planned execution by orderlies, nurses' aides, volunteers, and so on of particular contacts in the community which they may be uniquely in a position to undertake. Friendly visiting is not case work. But there may be occasions when the pressing need is not for case work at all (or is for something in addition to case work), and a friendly visit from one who has already established himself in a friendly status may provide the ex-patient a sustenance that cannot be found while he is trying to get acquainted with a total stranger determined to become a friend.

support for ex-patients; on the other hand, some relationships which may prove satisfying to a spouse or a sibling, may also generate stresses which a convalescent is hard put to withstand.

The social worker who can see the family only from the ex-patient's perspective will be unable to understand this network of interdependent roles and activities, this organism, this group. Here, to a greater or lesser extent, is a common way of life and not merely a cooping together of a number of disparate individuals. The ex-patient's fond memories of lemon meringue pie must be reconciled day by day with Junior's passion for chocolate pudding and with Sister's wish to lose weight without skipping dessert. From the ex-patient's description, Aunt Sue may sound like an obnoxious bore, but she may turn out to be the doting godmother of his youngest sister and, therefore, a very substantial fixture in the home. The social worker, in short, may find his skills pressed into service in helping to spin fine any of the ten thousand incidental moments of which the fabric of human relationships is woven. In facilitating the interpersonal relationships of the ex-patient with others, the social worker, of necessity also finds himself facilitating the relationships of others with the ex-patient.

Thus, from playing an enabling role in the ex-patient's renewal of life with his family, the social worker presses on to contacts with his own third "service population": the community at large. It is here that clinical services to an individual in need and services to the ex-patient population as a category become indistinguishable. The requested half-hour's conversation with the former employer of Mr. Brown may in fact turn out to be fruitful not for Brown after all, but for some Mr. Johnson—six weeks or six months later.*

The social worker helps carry the ex-patient's message to the community and to the community leaders. He may write letters and articles, make speeches before service clubs and over TV. But above all he knows that it is face-to-face conference that most effectively brings about understanding. He is the ambassador to the parent-teacher association and to the family physician; he may chat with shopkeepers and with neighbors, with landladies and with trade union shop stewards. He may know just what to

*The social worker's role as ambassador here calls for conversation and discussion —not for a lecture. Communication, of necessity, demands acuteness in listening as well as fluency in talking.

say to rank-and-file civil servants (in the state employment service, in the local public welfare department). And he must know how to say it. He seeks understanding, co-operation. To achieve these goals, he must be prepared to share with others information he possesses that they too must have if they are really to provide the help they have been charged with providing.

People working in service programs under voluntary auspices can also be involved in the rehabilitation process. The social worker will know whom to approach in the local family agency, in the settlement house, at the social planning council—and how to put the problem intelligently, succinctly.

In enlisting the aid of others, whether professional people or laymen, the social worker's professional skill helps him decide when to lead and when to follow. Many of the most successful initiatives on the behalf of ex-mental patients at the neighborhood and community level have originated with social workers who have had the good judgment to help a respected, dedicated local figure into the seat behind the wheel before the bandwagon even started rolling—social workers who had the good grace thereafter to refrain from competing like a back-seat driver.

It is behavior of this sort that contributes mightily to the image of the hospital that comes to be projected into the community. And here we come to the responsibilities of the social worker toward his fourth service population: his colleagues in the therapeutic milieu. In his extra-mural activities, both in interpretation and in civic planning about mental health problems in their broader applications, the social worker introduces the citizen to a hospital concerned with total community health; a hospital willing to shoulder a large part of the mental health job, yet positively affirming the appropriateness and real importance for mental health of work done elsewhere, by expert and by rank-and-file citizen alike.

It may be through the day-to-day operations of the social worker that the hospital truly comes to be a presence in the community. And as he makes his rounds, rounds which should frequently call him beyond the hospital's walls, the social worker performs, not only the task at hand, but a role as messenger for the stay-at-homes. He becomes a spokesman for colleagues at the hospital who are as concerned as he is about relations with the community, but possibly are not so free to undertake the herald's job. The social worker, as a responsible ambassador, makes a point of sharing

information with his colleagues, placing at their disposal whatever information they may believe can best help their work.

But the social worker serves the hospital staff in more ways than as ambassador. Along with his colleagues in other disciplines, he shares responsibility for administration, continually asking himself what can be done, especially at home, that is, in his own department, to simplify forms, to expedite procedures. His professional competence includes skills in grappling with the most basic of all operational questions: In the light of its assigned and accepted mission, can the hospital be said to be truly *functional?*

The social worker, like others on the treatment team, may have suggestions looking toward enrichment of the hospital's services: or his skill may be the very unglamorous one of recognizing and giving support to a worthwhile innovation suggested by a colleague in another line of work.*

In hospital after hospital, social workers have been in the forefront, along with psychiatrists and psychologists, in initiating a variety of programs employing group techniques (including, but by no means limited to, discussion) as a means of maximizing and making more effective mental health services to patients, to relatives, and to ex-patients.

Still another point of pertinence of expert social work is a growing understanding of the import of occupational, ethnic and social differences for the planning of both hospital and aftercare services. There is a rich literature in the social work journals to complement the epochal Hollingshead and Redlich study, *Social Class and Mental Illness.*** Month by month, in one hospital or another, social work practitioners out of their own professional experience, are helping to hammer out the questions yet to be answered by an advancing science of mental health. Many social workers are personally engaged in research projects or in facilitating interdisciplinary inquiries.

In setting its goals, every profession presents its practitioners with performance demands they can only endeavor to approxi-

*It was Dr. John Zubek, for example, head of the University of Manitoba's psychology department, who pioneered in researches demonstrating the value of intellectual training programs for patients over 50—persons previously regarded as incapable of significant improvement of performance after years of deterioration. (*New York Times,* May 8, 1960.)

**Hollingshead, A. B., and Redlich, F.: Social Class and Mental Illness. Wiley. New York. 1958.

mate. To complete an inventory of social work skills would necessitate a treatment of the subject too lengthy to suit the present purpose. Both social workers and their colleagues can put to good use brief, well-organized records detailing service processes and the diagnostic assessments that are necessary concomitants. (To be useful, of course, a record must clearly differentiate actual behavior from impressions, fact from inference.) To turn in another direction, social workers can make invaluable contributions at appropriate moments as team leaders and co-ordinators, accepting senior responsibility for those phases of the hospital's service process in which the skills and information most characteristic of social work are found to be basic.*

The social worker on the job should bring to bear skills contributing to the diagnosis of social malfunction. He should have a most refined sense of tempo, knowing when to encourage, when to sit tight, when to listen, when to speak, when to push, when to sustain, when to make what point clear to whom—and the best way to make the point. The social worker has a good understanding of the *rational,* as well as of the *irrational,* aspect of mentation. No matter what his job, every social worker is an educator; the more refined and imaginative his pedagogical skill the more people he can help, the more situations in which he can be effective.

As facilitator, as confidant, as counselor, as the one who helps shape situations which evoke and maximize the positive capacities of others, in all his four worlds—with patients, with families, with communities, with hospital staffs—the qualified social worker can pull his fair share of any load.

Summary

Social workers contribute to rehabilitation of the mentally ill through activities with (1) patients and ex-patients, (2) their families and personal circles, (3) people in key community institutions such as businesses, churches and welfare agencies, and (4) hospital therapeutic teams, including nonprofessional as well as professional personnel.

Services in teaching, counseling and the amelioration of interpersonal relationships are explained through examples typically

*Cockerill, E., and Margolis, H.: The concept of disability. Iowa State Conference of Social Work. November 1954.

arising in practice. The discussion concludes with a presentation of the social worker's role as an ambassador of the treatment team to the community.

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AN EXPERIMENT IN REPLACING GIFT DISTRIBUTION WITH WORK THERAPY ON A PSYCHIATRIC WARD

BY PAUL COMSTOCK AGNEW, M.D.

This paper reports a study carried out by the author on the 34-bed psychiatric service of a general medical and surgical Veterans Administration Hospital.* Findings are reported on the problem which was the original theoretical basis for the study: When psychiatric patients receive free gifts from the hospital or its auxiliary organizations, how is the therapeutic potential of the patients' hospital experience affected? The initial experiences with an experimental program of work therapy for psychiatric patients are reported also.

A problem was found in supplying cigarettes on the psychiatric ward. Patients were complaining because they did not have enough. It was decided to meet with all personnel in any way involved with the cigarette question and to tape the interviews for study and analysis.** Several such meetings were held with the personnel, and several with the patient group. These taped interviews constitute the major body of primary data reported here.

The Gift Policy

There were several sources of free cigarettes for patients with no funds. A patient can be declared indigent by attesting in writing to his absolute lack of funds, and the registrar is authorized by a Veterans Administration regulation to supply three packs of cigarettes a week to such a person. Another source of free cigarettes is the service organizations, several of which were distributing large quantities throughout the hospital. These were given out weekly to ward head nurses for distribution to patients or were used for gifts or prizes at entertainments. In addition, members of the women's auxiliaries visited the psychiatric ward weekly, distributing cigarettes, underclothing, socks, and toilet articles to any patient who wanted them, whether he was officially "indigent" or not. Money from the "urgent need fund" of the

*The Veterans Administration Research Hospital, Chicago, Ill.

**Transcripts of all tape-recorded interviews with patients and personnel have been prepared. The analysis of interview material is based both on observations during interviews and study of recorded data. It would be beyond the scope of this paper, and impractical, to include more than illustrative excerpts from the interviews.

social service department also might be made available to individual patients for purchase of any of these things. In spite of these seemingly adequate supplies, the patients complained that they could not get enough cigarettes, and various members of the personnel also felt this to be a problem.

Feelings of Personnel about Cigarettes

Discussions with the personnel involved revealed that this was an emotionally sensitive and "loaded" area. Everyone showed evidence of strong feelings and attitudes about gifts for patients. "Listening with the third ear," one could perceive the basic issue of dependency strivings, various defenses to deal with them, and corollary feelings aroused by the conflict. One might speculate that discussing cigarette smoking in itself was a trigger that stirred up "oral dependency" strivings. Less speculative was the evidence that the structuring of the personnel-patient relationship in terms of supplies of gifts stirred up these feelings.

It is well known that becoming sick and entering the hospital is generally felt to be a regressive experience, and feelings of dependency and passivity are stirred up which are handled in various ways by the ego defenses. Also, the personnel have to deal with feelings which are aroused by regressed patients. There seemed to be no reason why, on this service, these feelings were particularly focused on the issue of gifts for the patients.

There were two major complexes of feeling and attitude. The nurses and social workers seemed to make an emotional assumption that their proper role was to give unlimited supplies to patients. Typical of the statements embodying these feelings is that made by a nurse—in reply to an "accusation"—that she was "trying to provide these patients with all the cigarettes they want." Another nurse expressed complete sympathy with the patients who had no cigarettes for a week because of a slip-up in delivery and who "every day would greet me at the door saying we didn't get cigarettes yesterday. Are you going to get them for us today?" Other nurses said, "You can't make patients go without cigarettes." Those who expressed these feelings saw the whole problem as "not enough cigarettes." They felt frustrated, anxious, guilty and inadequate when patients' demands were not met. They felt angry at those who managed the sources of supply and kept urging these people to furnish more. They were all in favor of

supplying patients to the point where they made no demands for more.

In the other camp, were those whose feelings and attitudes were militant against gifts for patients. They had a lot of angry affect about it. One person observed, "There has been a heavier demand for cigarettes from the psychiatric ward. We get the same from patients on the medical ward who have psychiatric problems." Another said, "You are trying to supply every patient with all the cigarettes he wants to smoke, and if he doesn't get them he takes to raising hell and the nurses have problems." The feeling was expressed that "psychiatric patients are more grasping and demanding than medical patients ... It's the excessive demand that has been bothered about on the psychiatric service; patients on the psychiatric floor are the type that are more demanding."

This was echoed by the sentiment, "I think we have a responsibility to try to discourage this smoking and not cater to the patients' dependent needs." These excerpts from the interviews illustrate negative attitudes toward dependency strivings. The members of the personnel who expressed them placed high value on independence and self-reliance and were most disparaging of the behavior of patients who demanded free supplies.

To recapitulate, this matter was an affect-laden issue. The affect had to do with dependency strivings, defenses against dependency and corollary affects of anger, guilt, inadequacy, and anxiety. These feelings were aroused by the fact that the relationship between personnel and patients was structured in terms of the personnel handing gifts to the patients.

Patients' Feelings and Attitudes

One would get the impression from the aroused feelings of the personnel that the patients as a group were vigorously and unequivocally demanding that they be supplied with free cigarettes and toilet articles. At first the patients did talk in terms of their frustration at not having enough cigarettes. Interviews with the patients were nondirective and went forward spontaneously as patients brought up ideas. They expressed distaste for a situation where they had to depend on others to supply them with things they had always supplied for themselves. Such remarks as, "I personally feel that if I could, I'd rather buy my own,"

and, "My first choice would be to be able to pay for my own," were common. As the interviews continued, sentiments such as, "It's hard begging anybody for anything," and, "It makes me feel like a panhandler to take these gifts," were expressed. One patient said, "The hospital has given me so much that the added things like cigarettes are a little ugly to me." Another said, "I would like to earn these things. I would do anything—I would wash walls, etc."

One patient described his feeling on approaching the head nurse for cigarettes, "I feel just like a child saying can I have a piece of candy." There was almost universal expression that asking for cigarettes felt like begging. The patients felt depreciated and suffered a loss of self-esteem. All smokers (most patients smoked) and all without funds who needed underclothing and toilet articles, became emotionally aroused about this point: *Having to rely on gifts and ask for gifts made them feel depreciated and they would much prefer to be able to supply their own needs.* Patients with funds emphatically agreed that they would feel the same way if they were in the others' circumstances.

The patients, as well as the personnel involved, felt that this aspect of their relationship was in the area of dependency. Feelings of depreciation, inadequacy, loss of self-esteem, hostility and guilt were aroused by the patients' dependence for things they had been accustomed to supply for themselves. The relationship of patients to the hospital and personnel was colored by this set of feelings and attitudes.

Effect on Therapeutic Potential of Hospital

With the effects of this situation on both patients and personnel assessed, the question arose: "How does this affect the therapeutic potential of the patients' hospital experience?"

Both on theoretical grounds and on the basis of current experience with psychotherapy, it was felt that the gift aspect of the stay in hospital was anti-therapeutic. The feelings aroused—based on reality—could not be used therapeutically, as there was structuring of patient-personnel relationship in which patients were actually dependent and helpless, a matter unrelated to their treatment needs. Feelings stirred up were thus, not representative of transference and counter-transference, but were part of the reality aspect of the relationship. As such, they could serve only

to cloud and distort the emotional atmosphere needed for psychotherapy.

Possible Solutions

On the surface there appeared to be several alternative ways of dealing with the problem. One was to make unlimited supplies available, so that patients in need could always have all they wanted. But this would not solve the real problem which was not one of inadequate supplies, but was that of the affect mobilized by the actual structuring of the patient-personnel relationship.

Another possible solution was to abolish all free gifts. This would eliminate the troublesome element from patient-personnel relationship, but, unfortunately without further action, would leave untouched the plight of the patient who had no funds. He would have to go without cigarettes, toilet articles and extra clothing. Certainly such deprivation could not have therapeutic value.

The solution that seemed most constructive was to arrange to have the patients earn money to buy these items for themselves.

The Work Project

The author arranged for an employer* from the community to make work available for which psychiatric patients would be paid. An area of the dayroom was set aside; and the employer assigned supervisors to instruct patients and help them in the work. On the work days, the employer's supervisor would come to the dayroom a half hour before starting time, get out raw materials, and set up the work. The participating patients then came in and worked for three hours. They could work about 12 hours a week and earn from $15 to $20 a week. The supervisor collected the finished products, kept all records of production, and shipped out the goods for distribution and sale. The actual work consisted of assembling decorative "snowmen." About 20 different parts, made

*The Disabled American Veterans organization of Chicago became the employer. A committee of this organization, including experienced businessmen and industrialists, planned and managed the enterprise as a business operation. The members arranged distribution and sales of the products—which were a new type— both through local stores and through the state chapters of the Disabled American Veterans. Financially, they suffered a loss through miscalculation of the ratio needed between cost of production and selling price.

The Disabled American Veterans took part in this research project, in the hope of exploring new ways in which veterans' service organizations could help hospitalized psychiatric patients. The fact that the "employer" did not completely fulfill the definition of a real employer from the community was an advantage in the quest to define the sources of therapeutic value in work experience.

of plastic, cloth, and metal, had to be properly glued and pinned together; then each snowman was enclosed in a plastic bag; and numbers of them were packed and sealed in cardboard cartons. After a few days of initial "shakedown," the whole operation ran very smoothly. Production ranged between 50 and 150 snowmen per patient for a three-hour work period. Pay envelopes were distributed every Friday. The roles of the employer and his staff were kept completely separate from the hospital and its staff. The hospital or its personnel in no way became involved in the role of employer of patients.

Results

As a result of this program, no patient had to be without funds. Anyone who needed to or wanted to could earn from $15 to $20 a week and supply his own needs for cigarettes, toilet articles and underclothing. Work activity was scheduled as a regular daytime program and was also available on week-ends.

In the actual working out of the project, all patients without funds participated, and some others took part because they found the work interesting and rewarding. Requests or demands for gifts ceased. Distribution of free items from all sources ended; and, with it, ended the element in patient-personnel relationship which had stirred up so much anti-therapeutic feeling on both sides. Taped interviews with personnel members and patients gave clear evidence, on analysis, that these former feelings had disappeared. Both personnel members and patients approved of the work project.* Patients found the experience conducive to self-respect, as well as interesting and demanding. It gave them a feeling of increased self-esteem and self-reliance. They liked their contacts with the work supervisor. With him they found a relationship of mutual respect and mutual obligation. The evidence was convincing that the work project had eliminated the anti-therapeutic feelings described from patient-personnel relationship; but what had become of those feelings? Were they now repressed by both

*At no time did either the personnel or patients show or indicate resistance to the change from gifts to the work project. This was considered most unusual, and it seems logical to assume that the feelings evoked by the gift policy were distasteful to both personnel and patients; and that they felt at once that a change to the work project would eliminate these emotional conflicts. For a consideration of resistance to change, the author refers the reader to an article of which he is co-author, "Introducing Change in a Mental Hospital," Human Organization, 19:4, Winter 1960-61, Cornell University, Ithaca, N. Y.

patients and personnel? Were patients now acting out their dependency and regressive hostility? Had the feelings shifted to other relationships? From analysis of the interview data and other observations, it was concluded that the change in reality-structuring of patient-personnel relationship had actually eliminated the stimulus for the feelings and that they were no longer experienced. The question of whether and how this affected the therapeutic potential of the patients' hospital experience cannot be answered at this time by showing data to demonstrate increased progress in psychotherapy, shortening of stay, or higher discharge rate. Over a longer time, it may be possible to gather such data.

Observations on the Use of Work in Psychiatric Treatment

Introduction

During the course of the work project the personnel became impressed with other positive values accruing to the patients from this work experience, values not initially foreseen.

This project was not carried out as a controlled experiment. The observations, therefore, are strictly impressions. The personnel became interested in discovering (in a preliminary way) if work experience has therapeutic value for hospitalized psychiatric patients, and if so, why. Both the individual's psychology and a sociocultural frame of reference were kept in mind. Clues as to the sources of therapeutic value in work experience, clues that could later be explored more definitively in a properly designed, controlled experiment, were looked for.* It is felt that some such clues can be reported at this time. (For recent reports on the value of work as therapy, see this paper's bibliography, which was compiled to illustrate that subject.)

Sources of Data

It was possible to collect from ward nurses and the work supervisor both their own observations and patients' statements to them of their feelings about the work experience. Doctors reported these reactions as they came up in individual interviews. Finally, group interviews, held by the writer with the patients, were taped and studied. They were a rich source of data concerning feelings and reactions. From these observations a hypothesis was formulated.

*Such a research project has been prepared, and necessary arrangements to carry it out are in process.

Therapeutic Values of Work Experience and Hypothesis as to Sources

It was concluded from the data that work experience can have definite therapeutic value in treating hospitalized psychiatric patients. It (1) increases feelings of "self-esteem"; (2) increases feelings of "adequacy" and "self-reliance"; (3) decreases feelings of "separation" and "estrangement" from the outside community; and (4) decreases feelings of "helplessness" and "dependency."

There would be few to question that these are therapeutic affects. There are many directions that should be explored: (1) looking for correlations between various types of work experience and individual, dynamically-understood treatment needs, (2) determining which clinical conditions respond best to work experience; and (3) correlating socio-cultural background and past work experience with clinical response to work therapy.

Sources of Therapeutic Value in Work

The therapeutic value of work experience stems from four general sources: (1) modification of the dynamics of patient-personnel relationship; (2) the meaning of work in our culture; (3) the relationships of the worker with employer and work supervisor; and (4) the "bridge to the community" effect.

The modification in the dynamics of patient-personnel relationship in the ward under discussion was thoroughly gone into earlier in this paper. The possibilities of work, in shifting the dynamics of patient-personnel relationships in more therapeutic directions constitute, in the writer's opinion, one of the most important sources of its therapeutic value.

Work in our culture is a highly respected activity. It is a source of status, respectability, adequacy and identity. The patient who spends three hours a day, working to make a "real product" and earning pay for services, gains a number of values from this experience. He performs real work as he understands it. As compared with an experience in pure play or in playing at work, he gains a feeling of social adequacy and identity he could not otherwise have. He knows that his products will be sold and used in the community and are of real value according to all cultural standards; and he receives pay in money for his services—a sign and symbol of real value which knows no equal.

Through his relationships with the employer and the work supervisor, the patient acquires a social role besides that of patient. He has the role of employee of an employer from the community, who relates to him in a realistic, traditional employer-employee fashion. All the values of mutual respect, consideration, and fulfillment of mutual obligation are possible. There is no artificiality.* The patient is involved daily in a culturally significant social role with nonmedical, nonhospital people who perform the same activity with him in the hospital that they do with others in the outside community. From these relationships the patient can derive feelings that he cannot get from the doctor-patient relationship or from other relationships with hospital personnel. He can gain a feeling of social adequacy and a feeling of identifying with a respected social role.

One reaction of the patients was their concern and even anger that their products were at first labeled at sale as "Made by Mentally Disabled Patients." Some patients heard of it and reported it to others.

This reaction brought further investigation, and it was discovered that the patients felt their work should relate them to the community, not to their disability. They were acutely aware that their employer came to them from the community and that their products went out to the general public. The labeling gave them a public image of their identity and role quite different from the one they wanted to have.**

This "bridge to the community" effect of the work experience accounts for its decreasing patients' feelings of "separation" and "estrangement" from the outside.

For the greatest benefits to be derived from the four sources of therapeutic effect in a work experience, the work must be the "real thing." It cannot be pretending or playing at work. It cannot be doing jobs on the ward or working in the hospital laundry or kitchen, or working for a benevolent project of a service organization.

*The feeling that there is something artificial about occupational therapy is not infrequently heard from patients.

**The hospital, of course, immediately arranged to have the employer discontinue the use of this labeling. This and other reactions of the patients—such as questions as to whether the Disabled American Veterans had "Lady Bountiful" or "exploiting" motives—helped the writer toward developing the present hypothesis as to the sources of therapeutic value in work.

The work must come from industry in the community and must be a regular activity in factory or shop. The employer and work supervisor must be authentic ones from the community. The patient must be paid for his work on the same basis as other employees of the industry. The patients' products must be sold and used in the community. In this way only, can the sources of therapeutic value in a work experience be utilized to the fullest.

Summary and Conclusions

If it were possible to separate the process of therapy from the setting in which therapy is conducted, the writer would call work experience a factor which makes the setting more favorable for therapy. But of course it is not possible to make such a separation. In a hospital setting all elements of the patients' total experience are thought of as possessing more or less therapeutic potential, depending on how they can be used to meet therapeutic needs. Other areas of the patients' experience are undoubtedly of more crucial therapeutic import than the one just discussed. Work therapy is an addition to the treatment armamentarium that is in line with the long trend of lessening the separation between the patient and the community. It offers the patient a network of ties with the society and culture of his community while he is going about the business, through other means, of freeing himself to increase his participation in them.

The therapeutic value of work experience is that it affects patients' feelings in the direction of: (1) increased self-esteem, (2) increased feelings of adequacy and self-reliance, (3) decreased feelings of separation and estrangement from the outside community, and (4) decreased feelings of helplessness and dependency.

The sources of these therapeutic values in work are: (1) the modification of the dynamics of the patient-personnel relationship, (2) the meaning of work in our culture, (3) the patients' relationships with employer and work supervisor, and (4) the "bridge to the community" effect. These sources can be most fully tapped when the work experience is established along the lines suggested in this paper.

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THE PREDICTION OF SOME ASPECTS OF MARITAL COMPATIBILITY BY MEANS OF THE RORSCHACH TEST*

BY BARRY BRICKLIN, Ph.D., AND SOPHIE G. GOTTLIEB, Ed.D.

In 1956, Piotrowski and Dudek[1] showed that marital mates who remained together in spite of marital conflict had similar numbers of human movement (M) responses on their respective Rorschach records, while mates who separated under the same conditions had dissimilar numbers of such responses. The M responses were offered as a crucial measurement in marital compatibility.

The purpose of the present investigation was to expand these ideas, and to fashion a predictive instrument of wider scope. A major necessity was to validate the instrument on married couples for whom much more information was available than whether they had separated in the face of difficulty.

On the basis of the Rorschach work mentioned, and on the basis of data which have accumulated since, a Rorschach marital compatibility index was devised. The ideal test of such a device would have been to test a husband and wife, make a predictive commitment as to future compatibility on the basis of the index score, and then observe the interaction of the mates for a long period in a controlled but non-interfering manner in their "natural habitat." The difficulties of doing so are obvious. As an approximation of these goals, it was decided to use group psychotherapy sessions to gather information. The sessions allowed controlled observation of actual interaction, and had the additional advantage of encouraging communication between the mates.

The position was adopted that compatibility is only tested under conditions of increased communication. It makes little sense to speak of the "compatibility" of a noncommunicative couple. By using group therapy sessions to gather information it was also possible to control the period of observation (16 sessions over a four-month period) and possible to control the administration of a large battery of before-and-after tests and interviews. The major question was formulated as: What are the effects of increased communication on the marital relationship? And, can this be predicted by the Rorschach Test?

People seem to want to cherish the belief that "talking things over" invariably leads to a better interpersonal relationship. But

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no doubt many clinicians will have noted that this is not quite the case; there seem to be many marital relations that grow worse under conditions of increased communication. In a sense, this is the main problem to which this investigation addressed itself: In a stressful marriage, when is it therapeutically wise to encourage communication between the mates, and when is it best not to encourage such communication? Alternative courses of action in the latter instance might be individual therapy for each mate, or even active discouragement of communication, with or without therapeutic aid. But no matter what position one might take in relation to therapeutic intervention in marital relations, there is little question that it is valuable to be able to predict the response of a couple to increased communication.

Population and Data Gathered

Since the purpose was to study marital interaction in depth, it was necessary to limit the population to eight couples. All couples participating volunteered to do so, and all reported some degree of marital stress at the outset.

Four couples with children formed one therapy group, and four couples with none were assigned to another group. The husband and wife attended the same sessions. The sample was middle class in socio-economic status, and professional and semi-professional in occupational status. It included Protestants, Roman Catholics and Jews. There were seven white couples and one Negro couple.

A large battery of techniques was used to gather data, but only the Rorschach results are considered in this paper. The following tests were administered before and after the 16 sessions: Rorschach, TAT, various figure drawings and other drawings, sentence completion items, Bender-Gestalt, and Mosaic. A psychiatrist interviewed each participant before and after the sessions. In addition, each subject answered a long list of standard questions after the sessions. All data, including the test responses and the records of the sessions themselves, were recorded and transcribed to typewritten sheets.

Methodology (Rorschach)

Rorschach criteria to predict marital compatibility were formed prior to, and independently of, the administration of the tests.

Three hypotheses were formed, the combination of which yields a "Marital Compatibility Prognostic Score" for a given couple. The lower the score, the better the prognosis. Such scores were determined for each couple on the basis of the pre-therapy Rorschachs. The eight couples were then ranked from the lowest, or best, score through the highest or poorest score. The ranking was then dichotomized at the midpoint to form two groups: the four couples with the lower or better Rorschach scores (for whom the greater improvements in compatibility would be predicted as communication increased), and the four couples with the higher or poorer Rorschach scores (for whom poorer responses would be predicted with increased communication).

A psychiatrist, working independently with *post*-therapy as well as pre-therapy data, and transcriptions of the sessions, made the same type of rank assignments. He rated the eight couples from the one who improved most, to the one who improved least in compatibility over the entire interval of the sessions (four months) and then dichotomized his ranking at the midpoint to form two groups of four couples each. The four couples who in his opinion improved the more from before to after the sessions formed one group; the four who improved less over the same interval formed the other group. These two assignment methods, those based on the Rorschach pre-session marital compatibility prognostic scores and those based on before-and-after psychiatric opinion, were compared statistically. In addition, mean marital compatibility scores were computed for the two groups, as determined by the psychiatrist (more improved and less improved), and compared by the t test. Also, the couples were ranked in terms of most compatible to least compatible by the psychiatrist and by the marital compatibility scores. A Spearman's r was computed.

Aside from the three major hypotheses, which yield marital compatibility scores, some additional subhypotheses were formed, the results of which are reported.

The Rorschach Marital Compatibility Prognostic Score

When a subject perceives human figures or parts of human figures in action on inkblots, two things are of interest from an interpretive standpoint (Piotrowski, 1957, Chapter 6).[2] One is the quality of each of the perceived human movements, and the other is the number of human movements perceived in total. The

quality of a human movement, or M response, refers to the kinesthetic element of the figure. Interest in the kinesthesia of a perceived figure arises from the fact that it reflects some basic and deep-seated interpersonal attitude of the subject tested. (An interpersonal attitude may be defined as an attitude which will be activated under certain [specifiable] conditions in interpersonal situations which the person subjectively experiences as important.) An assertive kinesthesia indicates an assertive interpersonal attitude; a compliant kinesthesia indicates a compliant interpersonal attitude. The kinesthetic attitude, and hence interpersonal attitude, may be inferred from the relationship between the perceived figure and the force of gravity. A figure which overcomes the force of gravity is assertive, a figure which gives in to the force of gravity is compliant.

Of course, there are a host of extreme and intermediate values ranging from direct interpersonal aggressiveness, down to socially acceptable competitive aggressiveness, and, through compliance, right on down to passivity and abject submissiveness. These delicate shadings of variation in interpersonal attitudes are faithfully reflected in the variety of kinesthetic elements in Rorschach human movement responses. The total number of human movement responses reflects, aside from fantasy or "inner life," the complexity of a person's interpersonal attitudes, and the amount and complexity of interpersonal ideation.

Most Rorschach authorities have attested to the importance of the M response. The M response is among the most useful of any of the Rorschach components from a clinical point of view. Piotrowski has demonstrated the role of the M in the diagnosis of intracranial pathology (1937),[3] and Piotrowski and Lewis (1952),[4] and Piotrowski and Bricklin (1958)[5] its relation to prognosis in schizophrenia. Piotrowski has also shown the role of M in measuring personality changes (1937),[6] and its role in prognosis in schizophrenia for insulin treatment and for electric convulsive therapy (cited in 1957). Mirin (1955)[7] has demonstrated that M responses reflect attitudes of which the subject is at least partially aware, and which guide overt behavior.

In a more general sense, the M responses reflect the person's conception of his role in life (Piotrowski, 1957). From the M responses, may be inferred the attitudes by means of which the subject orients himself to those around him, and the attitudes he

will adopt when dealing with others in personally vital matters. Persons with assertive M will tend to rely on their own resources when involved in situations which are subjectively experienced as important; persons with predominantly compliant M when similarly involved will look for others to assume the ultimate responsibility. Persons with compliant M may act assertively, but will do so only if they can be made to feel that someone else is ultimately responsible for the consequences of their action. Piotrowski and Schreiber (1952)[8] demonstrated that the M response is stable over time, and is among the least likely of Rorschach components to change, other conditions being equal. Since the M reflect basic deep-seated, and highly stable personality characteristics, Piotrowski and Dudek (1956) surmised that mates who differ markedly in their numbers of M responses could not be expected to have a compatible relation, since there would be an inability to communicate complex attitudes, and an inability for one mate to accept the most basic, deep-seated, and unchanging personality traits of the other mate. Piotrowski and Dudek demonstrated that, among marital mates who were undergoing stress in their relationships, only those who differed markedly in numbers of M eventually were unable to remain together.

It was, therefore, hypothesized that in the present inquiry, those mates between whose before-treatment Rorschach records there were the smallest differences in numbers of the M responses, would be among those who would be independently designated by the psychiatrist as having improved to the greatest degree in compatibility from before to after the group sessions.

The difference in numbers of M between a husband and wife, then, was to be one component of the Rorschach compatibility score.

Since compatibility has been taken as the ability of two mates to communicate on a deep level, it was further hypothesized that the more improved mates would share more similar M qualities than the less improved couples. This is based on the assumption that true and deep communication depends on the ability of the mates to share deep-seated interpersonal attitudes. The quality of human movement responses reflects these basic and deep-seated interpersonal attitudes. Many sensitive psychotherapists (see the writings of Theodor Reik) have pointed out the role of the "responsive chord" in true and deep communication. The sensi-

tive therapist has the ability to reproduce in his own awareness the attitude which is being conveyed by the patient, and this is apparently the basis of complex, true and deep communication. This is not the place to surmise the reasons behind this phenomenon, but it may be mentioned that there is a rather large "economic" gain in such communication, since it renders superfluous the transmission of long "verbal chains" (informational verbal units which must be sent and received a unit at a time), and makes possible the conveyence of attitudes, large components of which are "feeling tones." The contention here is, then, that true and deep communication depends upon the ability of one mate to reproduce (or experience) the attitudes being conveyed by the other mate, and that the Rorschach human movement response reflects the existence and nature of these attitudes. To the extent that one mate lacks M response qualities (or interpersonal attitudes) possessed by the other mate, their capacity for complex communication will decrease.

In the present investigation a given human movement response was classified as one of the following: Aggressive (AGG): "Two people fighting." Assertive (ASS): "Two people dancing." Assertive Body Part (ABP): "A person with his arm raised in the air." Assertive Body Part plus Compliance (ABP+COM): "A person sitting down but with his arm raised." Compliant (COM): "A person sitting down." Passive (PAS): "A person lying down." Blocked (BLO): "Two people in a tug of war with neither winning." Danger (DAN): "A person teetering on the edge of a cliff desperately holding on." Sex Confused (SXCF): "That's a person, but I do not know if it is a man or woman. It has a penis and breasts." Distorted (DIS): "That's a man with a grotesque pinhead." These M qualities would respectively refer to the following interpersonal attitudes: (AGG) aggressive; (ASS) assertive; (ABP) limited assertiveness; (ABP+COM) ambivalent assertiveness; (COM) compliant; (PAS) passive; (BLO) obsessionally ambivalent, that is, great expenditures of mental effort with little or no result; (DAN) a feeling of being in danger, tense, anxious; (SXCF) an inability to form a consistent picture of one's sexual role in life; (DIS) a disparagement of other persons, a regressive and infantile orientation.

It may be noted that the last two categories, Sex Confused and Distorted, are not of the same nature as the other categories. An

M response could have the elements of sexual confusion in it but still be assertive or aggressive in quality. However, the sexually confused elements in the response would take precedence over the other qualities for the purpose of the compatibility scores. No matter what other qualities are present, a "Distorted" or "Sex Confused" element would receive precedence in these scores. As a general rule, the M categories given here were designed to be exhaustive and, for this study, exclusive (that is, every M was placed in one and only one category), but it must be remembered that no rigid coding system can do adequate interpretive justice to the rich nuance of meaning of the M responses. The writers feel that this particular division of the M response qualities has encompassed in a meaningful way the interpersonal attitudes most pertinent to marital interaction.

To measure the sharing of similar interpersonal attitudes or M responses, the notion of a non-concordance was adopted. A non-concordance in M was scored every time one mate had at least one M of a quality not had at all by the respective mate. In other words, the number of M is not the crucial variable here, but rather the sharing of similar M qualities. It made no difference how many M a mate had in a certain category, if the other mate had none of that type, a non-concordance was scored. On the other hand, even though a mate may have, say, seven assertive M and the other mate only one assertive M, this would not qualify as a non-concordance. The writers' speculation was that those mates between whose pre-therapy Rorschachs there were the fewest non-concordances, would be those mates who would improve in compatibility to the greatest degree from before to after the therapy sessions, on the basis of their having the greatest capacity for the communication of complex attitudes.

Sex confused and physically distorted human movement responses are indicative of an inability to accept one's sexual role in life, and are usually associated with an inability to assume full marital responsibilities (Piotrowski, 1957, pp. 359-360).[2] Consequently it was expected that the more a given husband and wife produced such responses, the poorer would be their chances to grow more compatible under conditions of increased communication.

A Marital Compatibility Prognostic Score is computed for a given couple, then, by adding the differences in the number of M,

the number of non-concordances, and the number of Sex Confused and Distorted M produced by each mate. These Rorschach hypotheses may be interpreted clinically as follows: The less one mate is able to accept the most stable, deeply entrenched personality traits of the other mate, the less the mates are able to communicate complex interpersonal attitudes, and the less each mate is able to assume a psychosexually mature role in life, the less is the chance that they will grow more compatible as they increase intercommunication.

Three sub-hypotheses were also formed. Positive color indicates a desire to share close and genuine emotional interchanges, superficial color a desire to share noncomplicated relations, and negative color a desire to withdraw from emotional involvement (Piotrowski, 1957, pp. 224-225).[2] It was expected that the couples with the better Rorschach marital compatibility scores would show increased positive color as communication increased, while those with poor marital compatibility scores would increase negative color under conditions of increased communication.

The more that weighted color responses predominate over weighted light-shading responses, the greater is the problem of maintaining adequate self-control, and the more likely is the individual to come into open conflict with others (Piotrowski, 1957, p. 282). It was expected that the couples with the better marital compatibility scores would tend to decrease the discrepancy between weighted light-shading responses, Σc, and weighted color responses, ΣC, (that is, would move in the direction of easier self-control) as communication increased, while the couples with the poorer scores would show an opposite tendency.

Psychiatric Evaluations of Marital Compatibility

Each participant was interviewed before and after the therapy sessions by a psychiatrist (Dr. Bernhardt S. Gottlieb). He had no knowledge of the test data. The following areas were covered for each participant: (1) The degree of psychosexual maturity, including the degree of acceptance of marital responsibility, was estimated. (2) All participants were asked questions concerning the number of times they had (with their respective mates) intimate conversations, sexual intercourse, and other mutually satisfying interactions. (3) All of the group sessions had been recorded with the records transcribed. These data were inspected

to see how many times the mates were mutually supportive, as opposed to being mutually antagonistic.

Using these criteria, the psychiatrist ranked the couples in terms of most improved to least improved in compatibility from before to after the group therapy sessions. For design purposes, the ranking was dichotomized at the midpoint to form two groups: the more improved couples, and the less improved couples. It was to this grouping that the grouping arrangement yielded by dichotomizing the Rorschach marital compatibility scores was compared.

Results

The most important part of the results may be most easily read from Table 3 (see the following analysis). The couples are arranged in that table, from top to bottom, in terms of lowest or best Rorschach pre-session marital compatibility score, to highest, or poorest. On the right-hand side, may be read the pre-session marital compatibility scores (0, 1, 4, 5, 7, 8, 10 and 14). On the left-hand side of the table are the ranks assigned to these same couples by the psychiatrist. (All tables follow this format.) For example, the top line of figures refers to the couple who had the lowest or best Rorschach marital compatibility score, 0. From the left-hand side of the table, it may be noted that this couple was designated as Couple Three by the psychiatrist. The second row of figures refers to the couple who had the second best compatibility score, 1. By reading the left-hand side of the table, it may be noted that this couple was also ranked second by the psychiatrist. It may be noted that the Rorschach scores and the psychiatrist agreed perfectly as to which four of the eight couples improved the more in compatibility from before (pre) to after (post) the sessions, and which four of the eight couples improved least over the same interval, although there was not perfect agreement in total ranking orders. Before looking at the results in more detail, it might be best to examine some other factors of possible prognostic import.

(Since there was perfect agreement between the Rorschach scores and the psychiatrist as to the four more improved and four less improved couples, when reference is made to the "more improved couples," those four who were found more improved by both the psychiatrist and by the Rorschach are meant.)

The mean age of the individuals who comprised the more improved couples was 31.0 years, the mean age of those who made up the less improved couples was 31.8 years. The mean differences in ages between the husbands and the wives of the more improved couples was one year; this same value for the less improved couples was six months. Two of the more improved couples had been married more than eight years, and two less than eight; This was also true of the less improved couples. The more improved couples had a mean of .75 children; the less improved, a mean of 1.25. There were four M.A. degrees among the more improved couples, and five among the less improved. There were three additional B.A. degrees among the more improved couples and three among the less improved couples. There was one member of the more improved couples whose schooling stopped at high school graduation. There were five professional persons among the more improved couples, six among the less improved. There was one semi-professional person among the more improved couples. There were two "housewives" in each of the groups; all couples were from among the "middle class."

There were two "mixed" marriages (in religion) among the more improved couples (a Protestant and a Jew, and a Protestant and a Catholic), one Catholic couple, and one Protestant couple. There were two Protestant couples, a Jewish couple and a Mormon couple, among the less improved. Six of the individuals in the more improved couples had both parents alive, and four among the less improved had both parents alive. Two persons from the more improved group had one living parent; and three from the less improved group, one parent. One from the less improved group had neither parent. The more improved individuals had a mean of 3.75 siblings; this value for the less improved group individuals was 3.25. The "mean" individual from the improved group was born number 3.35 in the family; this value for the less improved individuals was 2.75. There are no striking differences in any of the areas just covered, and one may conclude that in this (limited) sample, neither age, age differences, years married, number of children, education, occupational status, socio-economic status, religion, status of parents, number of siblings, nor family position was related to improvement or lack of improvement in marital compatibility. However, the data must be considered tentative, since it was not the purpose of this study to investigate

the roles of these factors, and the sample is far too limited to permit extrapolation.

Table 1 presents the distributions of M responses according to quantity and quality for all the couples. The top four couples are the more improved; and the bottom four the less. From this table,

Table 1. Quantity and Quality of M Responses Among Mates More and Less Improved Before (Pre) and After (Post) Group Therapy*

		No. M	AGG	ASS	ABP	ABP+ COM	COM	PAS	BLO	DAN	SXCF	DIS
More Improved												
Couple Three**	H Pre ..	1		1								
	W Pre ..	1		1								
	H Post .	1		1								
	W Post .	2		2								
Couple Two	H Pre ..	3			1	2						
	W Pre ..	2			1	1						
	H Post .	2		1	1							
	W Post .	1		1	X							
Couple One	H Pre ..	5			4	1	X					
	W Pre ..	3			1	X	2					
	H Post .	5			3		1		1			
	W Post .	2			1		X		1			
Couple Four	H Pre ..	10		3	3		3	1	X			
	W Pre ..	8		X	6		X	1	1			
	H Post .	7		2	3		2		X			
	W Post .	7		X	6		X		1			
Less Improved												
Couple Five	H Pre ..	3			1		1				X	1
	W Pre ..	3			X		X				1	2
	H Post .	4		1	1						1	1
	W Post .	4		X	2						2	X
Couple Six	H Pre ..	3			X						1	2
	W Pre ..	5			4						1	X
	H Post .	3			X	X	1				1	1
	W Post .	8			5	1	X				1	1
Couple Eight	H Pre ..	6	2	1	1						2	
	W Pre ..	1	X	1	X						X	
	H Post .	4	1	1	1				X		1	
	W Post .	1	X	X	X				1		X	
Couple Seven	H Pre ..	11	2	1	4			1		1	2	
	W Pre ..	4	X	X	4			1		1	X	
	H Post .	14	5	1	2		1	1		X	4	
	W Post .	4	X	2	X		X	X		2	X	

X=Non-Concordance

*Symbols designating columns are explained in the text in the description of the prognostic score.

**Numbering shows psychiatrist's ranking.

it is possible to see how the given marital compatibility prognostic score was computed for each couple "pre" and "post" the sessions. For example, in Couple Three the husband had one M on his pre-therapy Rorschach and the wife had one. Consequently, the sum of the difference in M is 0. There are no non-concordances, that is there is no instance where a mate of this couple has at least one M of a type not had at all by the respective mate. Neither mate produced Sex Confused or Distorted M. The pre-session marital compatibility prognostic score for this couple is 0. Now consider Couple Six, pre-therapy; the wife produced five M, the husband three. There is a difference of two in the number of M. There are two instances in which either the husband or wife produced at least one M of a type not shown by the respective mate. The wife produced four Assertive Body Part M; the husband none. The husband produced two Distorted M; the wife none. This yields a total of two non-concordances. The husband produced one Sex Confused M, and two Distorted M; the wife produced one Sex Confused M. Consequently, the total in this area is four. The marital compatibility prognostic score for this couple is eight (2+2+4).

Table 2 summarizes the mean values of the various M types for the more improved and less improved couples. It is of interest that Aggressive M appeared only among the less improved couples.

Table 3 summarizes the most important part of the investigation; it summarizes for each couple the differences in the number of M, the number of non-concordances, and the number of Sex Confused and Distorted M, yielding marital compatibility scores for each couple, before and after the therapy sessions. The essential methodology was to divide the couples into two groups, the more improved and the less improved, on the basis of the pre-session compatibility scores, and for the psychiatrist to do the same thing from independent data. The marital compatibility prognostic scores predicted perfectly (and in advance) the four more improved and the four less improved couples. The probability of this having occurred by chance is 1 in 70. There is no overlap in these Rorschach scores between the more improved and less improved couples. For comparative purposes, marital compatibility scores were computed from the postsession Rorschachs. Even if before-and-after scores are combined, and a total of six or more is taken as the critical cut-off point, there is still no overlap between the more improved and the less improved couples. As will be seen later, M is a highly

Table 2. Mean M Responses of Each Individual Mate According to Quantity and Quality Among Improved and Unimproved Categories Before (Pre) and After (Post) Group Therapy*

	AGG	ASS	ABP	ABP+ COM	COM	PAS	BLO	DAN	SXCF	DIS	TOTAL
More Improved											
Sum M Pre	0	5	16	4	5	2	1	0	0	0	33
Sum M Post	0	7	14	0	3	0	3	0	0	0	27
Mean M Pre	0.00	0.63	2.00	0.50	0.63	0.25	0.13	0.00	0.00	0.00	4.13
Mean M Post	0.00	0.88	1.75	0.00	0.38	0.00	0.38	0.00	0.00	0.00	3.38
Less Improved											
Sum M Pre	4	3	14	0	1	1	0	1	7	5	36
Sum M Post	6	5	11	1	2	1	1	2	10	3	42
Mean M Pre	0.50	0.38	1.75	0.00	0.13	0.13	0.00	0.13	0.88	0.63	4.50
Mean M Post	0.75	0.63	1.38	0.13	0.25	0.13	0.13	0.13	1.25	0.38	5.25

*Symbols designating columns are explained in the text in the description of the prognostic score.

stable Rorschach component (and changes in clinical criteria of compatibility are reflected first in Rorschach components other than M).

Mean values in marital compatibility scores for the more improved and less improved couples are significantly different according to the *t* test (p less than .01, for "pre" and "post" means). It should be pointed out that the striking difference between the two groups in number of Sex Confused and Distorted M is most likely a statistical artifact. It is unlikely that such a great difference will hold up to the same degree in future investigations.

The couples were also ranked in terms of most compatible to least compatible, both on the bases of pre-session Rorschach marital compatibility scores, and before and after psychiatric evaluations. Spearman's r was .88. The seven and eight positions were reversed by the two different methods, and the one and three positions. The psychiatrist placed, in the number three position, the couple the marital compatibility prognostic score would have put in the number one position, and he placed, in the number eight position, the couple the Rorschach score would have had in the number seven position. There was perfect agreement on all other couples.

Table 4 gives the distribution of color responses by quality for all of the participants. It was expected that those mates who earned less optimal marital compatibility scores would increase negative color as communication was increased, on the assumption that desires to withdraw emotionally would increase. The data in general support this expectation, although it is difficult to prove statistically with this small sample. Five of the mates who contributed to the poorer marital compatibility scores increased negative color from before to after the therapy sessions, while this was true of only two of the individuals who contributed to the better scores. Four mates who contributed to the better marital compatibility scores increased positive color as communication increased, while only one individual from the other group increased positive color.

The greater the discrepancy between weighted light-shading and weighted color responses, with the latter outnumbering the former, the more difficult it is for the individual to maintain self-control, and the more likely is the individual to come into open conflict with others. It was expected that the mates with the better marital compatibility scores would show a tendency to decrease this tendency

Table 3. Quantitative and Qualitative Aspects of the Human Movement Response in More and Less Improved Marital Couples Before (Pre) and After (Post) Group Therapy

More Improved	Differences in No. of M Between Husband and Wife		Non-Concordances in M Between Husband and Wife		Sex Confused Distorted M		Total Marital Compatability Scores	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Couple Three*	0	1	0	0	0	0	0	1
Couple Two	1	1	0	1	0	0	1	2
Couple One	2	3	2	1	0	0	4	4
Couple Four	2	0	3	3	0	0	5	3
Sum	5	5	5	5	0	0	10	10
Mean	1.25	1.25	1.25	1.25	0.00	0.00	2.50	2.50

Less Improved	Differences in No. of M Between Husband and Wife		Non-Concordances in M Between Husband and Wife		Sex Confused Distorted M		Total Marital Compatability Scores	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Couple Five	0	0	3	2	4	4	7	6
Couple Six	2	5	2	3	4	4	8	12
Couple Eight	5	3	3	5	2	1	10	9
Couple Seven	7	10	5	6	2	4	14	20
Sum	14	18	13	16	12	17	39	47
Mean	3.50	4.50	3.25	4.00	3.00	2.25	9.75	11.75

*Numbering shows psychiatrist's ranking.

Table 4. Color Responses According to Quality (Positive, Superficial, Negative) Among 16 Improved and Unimproved Marital Mates Before (Pre) and After (Post) Group Therapy

Couples More Improved		Pos.	Super.	Neg.	Couples Less Improved		Pos.	Super.	Neg.
Couple	Husb. Pre	0.0	0.0	0.0	Couple	Husb. Pre	0.0	1.0	0.0
Three*	Husb. Post	0.0	0.0	1.0	Five	Husb. Post	0.0	1.0	0.0
	Wife Pre	0.0	0.0	4.0		Wife Pre	0.5	1.0	1.0
	Wife Post	1.0	0.0	0.0		Wife Post	1.5	0.0	0.5
Couple	Husb. Pre	0.0	2.0	1.0	Couple	Husb. Pre	1.5	0.0	5.0
Two	Husb. Post	0.5	2.0	0.0	Six	Husb. Post	1.0	0.5	7.0
	Wife Pre	2.5	1.0	0.0		Wife Pre	3.0	0.0	0.0
	Wife Post	4.0	0.0	0.0		Wife Post	3.0	0.0	0.5
Couple	Husb. Pre	5.0	1.0	0.0	Couple	Husb. Pre	2.5	0.0	1.5
One	Husb. Post	2.5	0.0	2.0	Eight	Husb. Post	2.0	2.0	0.0
	Wife Pre	1.0	0.0	0.0		Wife Pre	0.5	2.5	3.0
	Wife Post	3.0	2.0	0.0		Wife Post	0.5	0.5	4.0
Couple	Husb. Pre	3.0	3.5	2.0	Couple	Husb. Pre	0.0	0.0	0.0
Four	Husb. Post	1.5	0.0	1.0	Seven	Husb. Post	0.0	1.0	1.0
	Wife Pre	1.5	0.0	1.0		Wife Pre	5.5	1.0	1.0
	Wife Post	1.0	0.0	3.0		Wife Post	2.0	1.0	3.0
Sum CR Pre		13.50	7.50	11.50	Sum CR Pre		13.50	5.50	11.50
Sum CR Post		13.50	4.00	7.00	Sum CR Post		10.00	6.00	16.00
Mean CR Pre		1.69	0.94	1.44	Mean CR Pre		1.69	0.68	1.44
Mean CR Post		1.69	0.50	0.88	Mean CR Post		1.25	0.75	2.00

*Numbering shows psychiatrist's ranking.

(that is, that the capacity for self-control would improve in this group), while the mates with poor scores would show the reverse reaction. It was expected that increased communication between mates with dissimilar interpersonal attitudes would weaken the capacity for self-control. These expectations are confirmed by the data. The groups were approximately equal in imbalances between shading and color before the increased communication, while there was a distinct tendency for the two groups to move in the expected directions after the group therapy sessions. The postsession imbalances between the groups are statistically significantly different (p equal to .04 on a one-tailed t test, Table 5).

Table 6 summarizes the variability of some of the major Rorschach components from before to after the sessions (ignoring the direction of the change, that is, whether the component increased or decreased). The components are ranked in terms of most to least variable. The human movement responses were the least variable of the major components.

Discussion

One factor to be considered in this study is the role of the group psychotherapy. No assumption was made of the effect of the group psychotherapy other than that it "forcibly" increased communication between mates. The therapist did her best to draw out all of the participants, and it can be reasonably assumed that all participants experienced a milieu that was conducive to increased communication. Very little interpretation was done by the therapist—just enough to keep the group minimally satisfied. All of the mates reported that the frequency of talking with their respective mates about themselves and their marital states increased. There would seem to be little risk in assuming that the experiment was conducted under conditions of increased communication. This is not an undesirable, or contaminating, or biasing state of affairs, if one subscribes to the notion that the essence of compatibility is communication. It seemed futile to question whether a couple was compatible under an ongoing condition of no communication. This does not mean to imply that the more the communication, the more the compatibility, or even that little communication implies poor compatibility, but that compatibility is tested under conditions of increased communication.

Table 5. Sum Shading minus Sum Color Responses for More and Less Improved Marital Mates Before (Pre) and After (Post) Group Therapy

Couples More Improved		Pre	Post	Couples Less Improved		Pre	Post
Couple Three*	Husb.	1.00	1.50	Couple Five	Husb.	2.50	—1.00
	Wife	—1.50	—1.75		Wife	—1.25	—1.00
Couple Two	Husb.	—1.50	1.00	Couple Six	Husb.	—4.25	—7.00
	Wife	—2.00	0.00		Wife	2.25	0.50
Couple One	Husb.	—0.50	—0.50	Couple Eight	Husb.	—1.75	—2.00
	Wife	0.00	—3.00		Wife	—4.50	—5.00
Couple Four	Husb.	—2.00	—2.25	Couple Seven	Husb.	2.50	—1.00
	Wife	—4.00	—2.00		Wife	—5.00	—4.00
Sum Imbalance		—8.00	—6.00	Sum Imbalance		—9.50	—18.50
Mean Imbalance		—1.00	— .75	Mean Imbalance		—1.19	—2.31

*Numbering shows psychiatrist's ranking.

Table 6. Mean Variability of Major Rorschach Scores Before (Pre) to After (Post) Therapy

Rorschach Score	Mean Variability
D	4.06
F	3.81
FM	2.13
Σ (d+8+s)	1.89
Σc	1.61
ΣC	1.56
W	1.31
M	1.13

Another point deserves mention. It is obvious that a correlation exists between the number of M responses produced, and the number of non-concordances. It is also apparent that couples who produce few M appear likely to receive the lower or better scores. Concerning the first point, it may be instructive to look at Table 1, Couple Five. Each mate produced only three M, yet they have three non-concordances (in addition to four Sex Confused and Distorted M). This couple earned a high or poor Rorschach score in spite of the fact that they each had three M. Yet Couple Seven, who differed by seven in number of M, also had three non-concordances. Although the number of M produced places a constraint upon the other components of the compatibility score, the constraint is apparently not detrimental to the validity of the score; nor is there evidence that the accuracy of the score would be improved by the removal of any component. As the number of differences in M increases, there is no evidence that the number of non-concordances increases at the same rate. Even where the difference in M is 0, there is no inherent likelihood that there will be few non-concordances, and even if each mate produces only one M, there is still a possibility of two non-concordances.

As far as the second point is concerned, that is, that those mates who produce few M appear likely to have the better scores, two factors are important. The first is: the fewer the M, the less likely is a person to take definite stands in life (Piotrowski, 1957). A simpler way of saying this is, other things being equal, the fewer the M, the less likely is the individual to argue. It makes sense from this vantage point that persons with few M should have an optimal chance to avoid conflict as communication increases.

Two mates, each with few M, are much less likely than persons with many M to be negatively affected by increased communication. Since two persons, each of whom has one M, share such an important personality trait (roughly equal complexity of interpersonal attitudes) it also makes sense that they should draw closer together under conditions of increased communication. The second factor concerning individuals who produce few M is: It should be noted that even if each mate were to produce but one M, they could still earn a marital compatibility score of four (two nonconcordances, two Sex Confused and Distorted M). Normal individuals rarely produce no M at all, but the writers' guess would be that if there were a nonpsychotic couple, each mate of which produced no M, increased communication would probably have a positive, but minimal effect on their relationship.

The major expectation of this investigation was that similar interpersonal attitudes, or similar M, would afford rallying points for certain couples, around which increased communication would help in ironing out differences. On the other hand, it was expected in cases where there were dissimilar interpersonal attitudes, and the M were indicative of an inability to accept marital responsibility, there would be no such rallying points. These expectations were confirmed by the data. As a point in fact, in the two couples who earned the poorest scores, compatibility actually became worse under conditions of increased communication. It seems possible to suggest that when marked divergences exist in the attitudes revealed by M, increased communication between mates leads to less rather than more compatibility.

As further evidence of the validity of the marital compatibility score, the two couples who earned the poorest scores had both instituted divorce proceedings as of the writing of this paper (which was more than a year after the ending of the group therapy sessions). It may be remarked that all eight of the couples were reached by the psychiatrist more than a year after the sessions ended. In his opinion there is no evidence to change any of his initial evaluations.

The last question to be answered is: In which Rorschach components did the couples with similar and optimal M responses show their "disturbance" in the first place? Since the couples with the good prognoses began and ended the sessions with optimal M, why were they having difficulties in the first place? The data

would indicate that the answer is in the distributions of color responses, and in the difference between light-shading and color responses. All couples at the start of the sessions had non-optimal distributions of color responses, (that is, the mates differed in quality, frequency of activation, and intensity of affect) and of imbalances of weighted light-shading responses and weighted color responses (that is, they all had poor self-control). The couples with the poorer M responses showed a tendency to increase negative color (a tendency to withdraw emotionally) as communication increased. On the other hand, four persons of the more improved group increased positive color (tendencies to seek positive emotional interaction) while this was true of only one of the individuals from the less improved group. The mates in the more improved group showed a tendency to move toward the direction of more optimal self-control; the mates in the less improved group showed the opposite tendency.

Summary and Conclusions

Three facets of the Rorschach human movement response were used to compute a Marital Compatibility Prognostic Score. The higher the score, the poorer the potential compatibility. This study would suggest 6 (or more) as the critical cut-off point to differentiate the couples with the poorer compatibility potential. Eight married couples attended 16 sessions of group psychotherapy, in which all interaction was recorded. These couples were tested with a wide battery of tests, including the Rorschach, before and after the therapy sessions. In addition, each participant was interviewed by a psychiatrist (who had no knowledge of the test results) before and after the group therapy. Also, each participant answered a lengthy list of standard questions; and sociometric data were gathered after the group sessions. Marital compatibility prognostic scores for each couple were computed on the basis of pretherapy Rorschach tests. The psychiatrist, on the basis of both before-and-after interview data and transcriptions of the actual therapy sessions, assigned each couple to one of two groups. One group contained those couples who, in his opinion, showed the greater improvement in compatibility from before to after the sessions. The other group contained those who showed lesser improvement over the same four-month interval. The marital

compatibility prognostic scores successfully reflected his independent judgments. The following conclusions seem warranted:

1. Three facets of the Rorschach human movement (M) response can successfully predict certain aspects of marital compatibility. The smaller the difference in numbers of M responses between a husband and wife, the fewer the non-concordances in M qualities, and the fewer the Sex Confused and Distorted M, the greater is the probability that compatibility will improve as communication between husband and wife increases.

2. It is believed that the Rorschach factors mentioned are equivalent clinically to the ability of each mate to accept the most stable, and deeply entrenched personality traits of the other; to the ability for true, deep, and complex communication, and to the ability to assume mature psychosexual roles in life. In other words, the Rorschach Test furnishes the clinician with an objective means of measuring these parameters.

3. Not all married couples profit from increased communication or from "talking things over." As a matter of fact, there is reliable evidence that compatibility becomes worse among some couples as communication increases. Negative color on the Rorschach measures the tendency to withdraw from emotional interaction; those mates who had the poorer marital compatibility scores increased negative color as communication increased, while this was not true to the same degree of the mates with better scores. The discrepancy between weighted light-shading and weighted color responses reflects the capacity for easy self-control. This discrepancy became greater among those couples with the poorer Rorschach scores (that is, it became more difficult for the individuals to maintain self-control) while the opposite was true of the couples with the better marital compatibility prognostic scores. It is possible to suggest that when husband and wife of a given couple each earn a poor score, communication between them should be discouraged, and/or each should be urged to enter individual psychotherapy.

4. Further experimental work is called for in this area. It is extremely difficult to enlist the aid of married partners who will agree to attend the same group sessions for a lengthy period, and who will submit to lengthy testing and psychiatric interviews. For this reason, it is difficult to obtain large samples; and, further, it is difficult to process this type of data for large samples. The

writers' feeling has been that it is better to investigate relatively few couples in depth, rather than a great many couples more superficially.

5. Since all participating couples reported in this investigation were experiencing marital stress at the start of the sessions, the safest extrapolation would be to apply these results to the same type of couples. The authors feel that the method should be used, for the time being, primarily to answer the question: How will a given married couple, now experiencing a stressful relationship, react to increased intercommunication?

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MENTAL HEALTH ASPECTS OF PREGNANCY

BY JAMES J. LAWTON, JR., M.D. AND FRANK J. SISKO, M.S.S.

In every woman there is conflict between the biological, psychic and cultural urges which drive her toward her feminine destiny[1] and the opposing factors which turn her away from it. The latter forces include such conscious, realistic considerations as poverty, poor health and marital strife, as well as unconscious factors of guilt, rejection of the feminine role, or fear of bodily mutilation during the birth process. In an emotionally mature woman who finds herself pregnant, the interaction of these opposing forces may cause a temporary conflict, expressed in symptoms of tension, emotional lability, depression, insomnia, nightmares, nocturnal anxiety, headaches, nausea, shortness of breath, constipation or a perverted sense of touch and taste. Usually this conflict is resolved, unless the combined realistic, conscious problems and unconscious conflicts are overwhelming or unchangeable. In the woman whose emotional difficulties have never been settled, the pregnancy may impose a heavy burden on an already inadequate personality, causing a constellation of emotional problems which result in a breakdown of function. The internal conflictual difficulties and unconscious distortions of reality are apt to be more critical than the environmental issues.

No one will deny that there are "bad mothers," in the same sense in which there are bad partners in every type of human relationship. The relationship of a mother to her infant is an exacting one, and it is too much to expect that she will fulfill her task satisfactorily if she has not taken on the role of motherhood voluntarily. Anna Freud[2] designates as the "unwilling," all those mothers who never meant to have a baby, or did not mean to have it at the particular time when pregnancy occurred. The reasons for unwillingness may be external, such as financial difficulties, lack of one's own home, or of space, the burden of too many earlier children or the illegitimacy of relations with the child's father. Anna Freud further points out that emotional reasons, such as lack of affection for the husband may be extended to the baby. In addition, many women are incapacitated for motherhood by virtue of masculine tendencies. They may wish for children for reasons of pride and possessiveness, but their humiliation at finding themselves female, their longing for a career, or their

competition with the husband, preclude any real enjoyment of, or with, the soon-to-arrive baby. Anna Freud also feels that there are, further, the mothers who waver between rejection and acceptance of the mother role. A woman may be wholly unwilling while pregnant, and then be seduced and tempted by the infant until she can enter into an affectionate relationship. In such cases, the living presence of the child may arouse what could be called the maternal instinct.

In a study done at the Philadelphia Lying-In Hospital,[3] 46 per cent of 59 women (27 patients) had sufficiently severe symptoms to warrant psychiatric diagnoses. They exhibited such symptoms as depression, insomnia, nightmares, and even more classical neurotic reactions like conversions, phobias and obsessive-compulsive thinking. However, there was not always a need for psychiatric treatment, and a majority showed progressive reintegration and a disappearance of symptoms. Of these 27 with symptoms, 41 per cent (or 11 women) had had some period of emotional disturbance before pregnancy, warranting a psychiatric diagnosis; and future breakdown under stress could be expected.

Of this group with disturbances before pregnancy 66 per cent (or seven women) were predominantly rejecting at conception, 37 per cent at term, and 12 per cent post partum. This was not only revealed in conscious attitudes but in slips of the tongue and in symptoms and dreams, often in marked contrast to a consciously accepting attitude. This study further emphasized that at conception, rejection of the child is not necessarily pathological; at term it generally is; and it practically always is when it is present in the period immediately following birth. Women of this last group who were pregnant for the first time were more rejecting at term as compared to those who had previously had children. This would tend to show that multiple pregnancies can help to temper many misconceptions, do away with fears and anxieties and possibly aid in achieving a higher degree of maturity.

At this point, the authors might mention natural childbirth and observe that there is no doubt that a woman can be helped to a more satisfying pregnancy and delivery through attention to the emotional state by means of reassurance, support and education.[4] Important elements considered to be involved are a trusting, dependent relationship on the doctor, which tends to alleviate anxiety, and the patient's active participation in the birth process.

Thus a sense of mastery becomes more important than the actual limbering up of muscles. However, it can be emphasized that the principles of natural childbirth are a general application of sound psychological concepts which should be integrated into the everyday practice of obstetrics for use with the pregnant woman.

A special aspect of maternity problems relates to unwed mothers. In 1949, there were over 133,000 out-of-wedlock children born in the United States.* Neither exploitation** nor punishment of unmarried mothers will solve the difficulties that arise in this area. Greater public understanding is necessary to prevent panic reactions and desperate clutching for secrecy, and to aid in establishing practical resources to meet these problems. These resources should include financial assistance, maternity shelters and casework services. Protection for illegitimate children should include the means necessary for their long-term care, with effective and uniform adoption laws.

Young[6] has exhaustively studied the psychology of unmarried mothers. It has been established rather conclusively that very few of them are interested in the men (as persons) with whom they are involved. Many of these mothers are shy, timid girls who led protected, isolated lives before meeting the fathers of their children, in more often than not, very casual, unconventional ways. Sexual experience frequently occurs at a time of stress in the life of the girl.[7] The first attempt to leave home, upsetting changes in the family, or the legitimate pregnancy of a sister with whom a girl has been in strong competition are frequent precipitating factors. The degree of emotional health of these women may be measured in part by the extent to which they are able to acknowledge or recognize their own roles in creating the problems that they face in their illegitimate pregnancies. Many factors in the situation of unwed mothers, of course, throw light on the problems of the married as well.

The obvious factor in many cases of unmarried motherhood is the very strong wish for a baby—without a wish for a husband—and it is interesting to observe that illegitimately pregnant women almost never lose their babies during pregnancy. In a study at the Booth Memorial Hospital in Boston,[8] it was revealed that there was only one miscarriage in 900 cases. The figures are

*Figures by Young.[6] The 1959 Bureau of Census figures are over 210,000 a year.

**By the black market for adoption of illegitimate babies.

somewhat distorted, because these girls are usually not seen during the first three months of pregnancy. But studies in 300 cases indicated no nausea; and contrary to expectations, there seemed to be an unusual degree of contentment with the pregnancies.

The drive which propels many an unmarried mother to become pregnant is a compulsive action, a need to act out an infantile fantasy. The woman is unable to consider the reality of the child in her plans, and the baby seems merely a symbol, the realization of her maternal and creative role. Ordinarily, the baby is not born out of love but is a narcissistic extension of its mother, loved or despised. Such a mother may be able to love or be helped to love her baby through re-education or psychotherapy.

The answer to the why of all this illegitimacy can only be sought in a girl's past life, home and childhood. One fundamental thing is the consistent pattern of domination by one parent. An unmarried mother is very seldom from a home where the parents love and respect each other or share family experiences and parental responsibilities. The domination by one parent deprives the girl of a normal relationship with either one.

Studies would indicate that the majority of unwed mothers are from homes dominated by a mother who never fully accepted her own feminine role and who generally married an extremely passive man.[9] The problems created by such mothers were chiefly those of acts of commission, while those created by the fathers were by acts of omission. In spite of close ties with their mothers, such girls are more often than not forbidden to express any sort of hate or rage feelings. They often turn these emotions on themselves in a pattern of self-punishment. There is a great deal of jealousy shown, and revenge achieved, in having an out-of-wedlock baby; it is a rebellious act against mother and father. The illegitimate children are often given to grandmothers even though the pregnancies were hidden from them for a long time. In fact, there seems to be more concern about the giving of the baby to the grandmother than there was in having it, indicating a misguided and displaced super-ego concept.

The unwed mothers who have domineering fathers describe them as rejecting, tyrannical, cruel and abusive. In such cases, there is usually no direct and open opposition toward the husband by the mother, and she frequently attempts to protect her daughter by means of vicarious behavior and subtle attitudes. Unmarried

mothers whose families do not fall into either of the categories of domineering parents, are likely to be secretive and withdrawn. This may indicate the overwhelming nature of everyday adjustments, which are characterized by free floating anxiety and poor frustration-tolerance. Such women seem to exhibit a striking inability to form meaningful emotional relationships; and while they rarely oppose authority, they very seldom really accept it. They often have no standards of their own, retain little control over their impulses, are extremely suggestible and are content to just drift through life. Their IQ's are difficult to measure, because of the marked extent of their social and emotional disorganization. They repeatedly appear to be like little children, lost and bewildered in an adult world, with little sense of guilt or responsibility. They are their own hapless victims.

In marriage and conventional families, prospective fathers present an area of understanding which has been somewhat neglected.[10] The husband's responses, early in the wife's pregnancy, have meaningful implications in relation to his later role of actual fatherhood. The father-to-be should understand what forces are set in motion from the first moment of his realization, joyous or apprehensive, that a new life, for which he will have to share responsibility, is an imminent reality.

The meaning of the experience of approaching fatherhood has its own psychological reactions, both positive and negative.

On the positive side, the pregnancy is obvious evidence to the man and the outside world of his inherent sexual virility and creative potency. Along with this, is the subjective experience of the realization of creative energy and power, contributing to a feeling of being a complete man. There is also the fundamental satisfaction in the forthcoming fulfillment of having progeny. This gives him a feeling of belonging, in terms of ontogeny and phylogeny. Finally, there is the satisfaction and pride of bestowing upon his wife, evidence of his love in enabling her to realize her womanhood fully.

For many men the prospect of fatherhood rekindles thoughts of childhood unhappiness and emotional deprivation in relation to their own parents. It can cause a temporary regression, as a result of the overwhelming sense of responsibility, resulting in the husband's seeking protection from his wife. There may even be an awakening of the Oedipal situation with his own mother, and

the wife may find herself forced to function as a mother substitute. She then finds herself in an ambivalent emotional relationship, not previously experienced, with her husband. Instead of his being able to accept the pregnancy as evidence of their mutual love, he may become demanding, inconsistent, insecure and unable to give his wife emotional support. His behavior may become confusing, provoking her into unnecessary anger as a result of his attempts to minimize the importance of the pregnancy. Latent neurotic patterns may emerge and the wife, not comprehending her husband's regressive behavior, may feel that her love is being rejected at a time when she is most vitally in need of a close, supportive relationship.

The everyday problems of marital adjustment may become magnified and difficult to resolve. The husband, not recognizing his own mixed, hostile feelings, may project his internal conflicts onto his wife and begin to feel rejected by her. The maturity or lack of it, in the marital partners will determine the extent of the harm that may result. The obstetrician, seeing both husband and wife with warmth and understanding, may help to avoid many of these difficulties. All too often, the prospective father is not seen at all, or if he is, not for any meaningful discussion of his impending experience.

When the child arrives, much depends on the mother's attitude, as to whether the father ever gets to know the baby.[11] There are many reasons why it is difficult for the father to take part in the infant's upbringing. Because of his job, he may seldom be at home when the baby is awake; and when he is at home, there may be temerity in his approach. Furthermore, the mother may cause him to feel he is in the way and give him a sense of emotional, as well as physical, inadequacy in the handling of the newborn. It also may be more convenient for the mother to get the baby to bed before the father comes home. She has had a lot of baby during the day and may want her husband to herself. The father, in turn, may feel that the mother is attempting to keep the child from him. Experience has shown that it is a great help in the relations between married people when they share, day by day, the little details of the care of their infant, little details which seem silly to outsiders but which are tremendously important at the time both to the parents and to the child. The father should have the opportunity to hold and feed the baby, even putting it

to sleep some evenings; and the changing of diapers should not be an exclusively female prerogative. As the baby grows, the richness of sharing the product of their love helps to deepen the bond between mother and father and makes them capable of even more love and understanding of each other.

Many fathers are shy about babies at the beginning; and no doubt, some can never be brought to see a baby as anything but fragile—a reaction which may represent the man's basic fear of hurting or being hurt. But a mother can get her husband to help in little things and can arrange, for instance, for baby to be bathed when the father can watch and take part if he wants to. He needs the meaningful awareness of baby's emotional response to him, whether a smile, a coo, or some other sign of recognition.

Some fathers feel that they can do better jobs in rearing children than their wives, and they constantly minimize the mothers' skills and capacities.

English[12] has written on the role of the father and notes his importance as: (1) a companion and inspiration for the mother, and (2) the awakener of emotional potentials of the child, among other numerous variant roles.

The promotion of good mental health in prospective mothers and fathers is of paramount importance in assuring a healthy emotional climate for the newborn. A better understanding of the emotional factors and conflicts which can exist for husband and wife during the pre-natal period[13] is one way of insuring the maximum atmosphere and opportunity for the full development of the newborn's potential personality growth. Much stress and attention have been focused on the critical importance of the mother-child relationship during the first years of life; but little psychiatric literature is available and not much research has been done about husband and wife and their interaction in the pre-natal period, or about the awakening of their own unconscious, internalized, personal conflicts.

Summary

The authors, in this short paper, have explored the literature and attempted a review of the subject, besides utilizing their own clinical experience in attempting to clarify some of the mental health aspects of the pre-natal period. They have attempted to demonstrate that there are conflicts of varying degrees in every pregnant woman as a result of both conscious, realistic factors

and unconscious mental mechanisms over which she has no control. In a significant number of cases, psychiatric attention is found warranted, at least on a diagnostic basis. The importance of a trusting, supportive relationship between patient and doctor, and the application of sound psychological principles in obstetrical practice is stressed.

The problem of the unwed mother is explored as a possible means of shedding light on the conscious and unconscious difficulties that may be experienced, at least in part, by all pregnant women. It must be noted of course that the psychological picture of the unwed mother is uncomplicated by the presence of a father.

An attempt is made to convey the importance of the prospective father in the total pregnancy situation, and to give some clarification of the meaning of the experience for him. No conclusions are reached; some speculations are offered; and it is hoped that this article may stimulate others to explore further into this pre-natal period. It is felt that the answer to many problems of preventive psychiatry, as well as a broader approach to mental health, can be found in this relatively untouched field.

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THE DURATION OF OUT-PATIENT PSYCHOTHERAPY*

BY EUGENE B. GALLAGHER, Ph.D., AND STANLEY S. KANTER, M.D.

It is an experience common to many psychiatric clinics that the bulk of psychotherapy patients drop out of treatment soon after they start. The familiar phenomenon of drop-out is dismissed as one of the altogether prosaic, unremarkable facts of clinic life. Drop-out patients are regarded as having been poorly motivated for psychotherapy in the first place, unsuited for it, or unlikely to benefit much from it if they *had* continued. These characterizations, whatever their validity, obviously serve the function of burying further concern about such patients. The early departure of patients is often viewed, from the superior perspective which hindsight gives, as absolutely inevitable. Also, there is the not uncommon remark that so-and-so dropped out of treatment because it was too painful for him to face himself. In this way, drop-out is seen as a merciful terminus from demands too great to be borne. Once again, effective concern about drop-out is sealed off.

Interest in studying drop-out thus stands at variance with the tendency to dismiss it as trivial, routine, or beneficent. Drop-out is an important alternative among the possible outcomes of the individual psychiatrist-patient relationship. As a massed, repetitive event, drop-out is an important parameter of the clinic's functioning in the community. Further, in a period when psychiatry with its specific techniques and its broader culture has increasing influence in American life, the drop-out phenomenon has, the authors believe, an important bearing upon the actual utilization of psychiatric services.

Prevalence of Drop-Out

One may briefly document the assertion that drop-out is a widespread occurrence.[1] At many clinics, it is not at all unusual for the majority of patients to stop coming to treatment after only five or six weekly sessions. Nash and his associates give figures

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from a Baltimore psychiatric clinic which show that, of one series of 48 new patients, 20 attended less than four treatment sessions.[2] This amounts to 42 per cent of the patients terminating treatment early. Garfield and Kurz, in a study of a Veterans Administration mental hygiene clinic, report that 43 per cent of a series of 560 patients who started psychotherapy had four or fewer interviews;[3] 67 per cent had nine or fewer interviews. Myers and Schaffer, reporting on a New Haven clinic, find that 54 per cent of a series of 114 patients admitted to treatment remained less than 10 weeks.[4]

These figures deal simply with *duration* of treatment. It is important to know whether a patient whose treatment lasted briefly terminated it unilaterally, or whether the psychiatrist was a party to termination. Only the former case is to be counted as a drop-out. That is, a drop-out is defined for the purposes of this paper as a patient who, without psychiatric assent, terminates attendance in an early stage of treatment.

Of the studies cited, the one by Nash and associates clearly states that therapists were instructed to retain all patients in treatment at least six months, as part of a research design. One may therefore assume that the 42 per cent of patients who terminated treatment early were all drop-outs, leaving treatment without the therapist's assent.

The Garfield-Kurz study gives explicit data which show that 66 per cent of all terminations, over all treatment durations, were at the patient's initiative. Applying this figure to their previously-cited report of a 67 per cent rate of termination before the tenth appointment, it can be conservatively concluded that 44 per cent of the patients whom they considered were drop-outs by the tenth interview.*

The Myers-Schaffer study does not include data on frequency of drop-out, nor are reliable deductions possible. However, the clinic is described as giving long-term expressive psychotherapy. Hence it is believed that patients with less than 10 weeks of treatment are predominantly drop-outs.

Long-term psychotherapy is the principal, if not exclusive, treatment emphasis in the three clinics cited here. However, many of

*It cannot be ascertained that the *over-all* 66 per cent rate of patient-initiated termination applies uniformly over all ranges of treatment duration, which in the Garfield-Kurz data are tabulated up to 25 or more appointments. It is suspected that the rate of patient-initiated termination is even *higher* for *shorter* treatment durations. If so, the 44 per cent drop-out figure is a conservative estimate.

the considerations pertaining to drop-out also apply, it is felt, to clinics where, as a matter of formal clinic policy, treatment for most patients consists of so-called "brief" psychotherapy. Clinics where this policy prevails frequently do, in fact, have a certain number of long-term therapy cases. The policy of predominantly short-term therapy often reflects, the authors think, an attempt to gear policy to the actual facts of clinic operation, which typically include high turnovers of patients and high drop-outs.

Present Study

A. Aims of the Project

The aims of this study are as follows: 1. *To determine the extent of drop-out in a Boston psychiatric clinic.* 2. *To determine the influence upon drop-out of three variables: type of psychiatric treatment, diagnosis of patient, and patient's social status.* 3. *To compare the Boston clinic with a New Haven clinic,* in terms of social class of patients, and drop-out rates. A picture of the comparative movement of the patient population through the two clinics, from intake to treatment to drop-out, will also be presented.

B. Treatment at the Boston Evening Clinic

This study deals with patients at the Boston Evening Clinic. This clinic was established in 1927 as a private general medical agency offering a variety of low-cost diagnostic and treatment services to working people in metropolitan Boston. The psychiatric clinic was inaugurated in 1956. It operates two evenings a week. Clinic policy restricts treatment to fully employed persons who cannot make arrangements to obtain treatment at the several daytime psychiatric clinics in the Boston area. Thus, evening hours are saved for patients who can have treatment only at that time. The psychiatric clinic, like its parent institution, is oriented to community service, offering long-term psychotherapy to out-patients. It also provides supervised training in group therapy for psychiatric residents and clinical psychologists.

The present study of psychiatric patients is based upon case records of all patients seen for initial evaluation at the clinic between its beginning in 1956 and November 18, 1959. In this period, 633 patients completed their contacts with the clinic; or, if in

continuing treatment on the latter date, had attended at least 21 treatment sessions. Table 1 shows the disposition of these 633 patients. One hundred forty-seven patients, or 23 per cent, show no disposition. Almost all these patients dropped out of contact with the clinic after a single evaluation appointment. They failed to keep second—or in some cases, third—evaluation appointments.

Table 1. Disposition of Patients Initially Seen at Boston Clinic, 1956-1959

	No.	Per cent
Referred elsewhere	183	29
No disposition made	147	23
Offered treatment at clinic	303	48
Total	633	100

Hence, the clinic could not make case dispositions. These patients constitute a group of very early drop-outs in the sequence of events leading up to treatment. They will not, however, be dealt with further in this paper.

Another group of patients—183, or 29 per cent of the 633—were referred elsewhere for treatment. Referral elsewhere occurs for a variety of reasons. Some patients had incomes too high for clinic treatment. These were referred for private treatment. Others were referred to day clinics, upon determination that daytime treatment was possible for them. Others were referred to more conveniently located sources of psychiatric help. A few were immediately hospitalized upon indications of overwhelming disturbance.

The remaining 303 patients—48 per cent of the 633—were offered psychiatric treatment at the clinic. Table 2 shows the duration of treatment for these patients.*

It should be explicitly noted that these figures deal with duration of treatment, rather than drop-out in the sense specified here.

*Four patients whose diagnoses were in the category, "Transient Situational Personality Disorders," (*American Psychiatric Association Diagnostic Manual*, 1952) were eliminated from the treatment group, leaving an N of 299. The rationale was that these patients, whose illnesses were presumably temporary in duration, of recent onset, and induced by external stress, differed from the others in significant respects. Psychotherapy aims to cure or alleviate intrapsychic illness. It is not clear that the staff expectation of continued participation in therapy applied to patients whose disorders were primarily situational rather than intrapsychic.

Table 2. Percentages* of Patients Remaining in Treatment for Specified Periods

1 or more sessions	4 or more sessions	9 or more sessions	14 or more sessions	21 or more sessions
Per cent	Per cent	Per cent	Per cent	Per cent
74	44	30	22	16

*100 per cent, N=299 patients

The present data do not, unfortunately, enable definite discrimination of drop-outs from persons having other reasons for terminating treatment. However, it is believed that virtually all treatment terminations before four months are drop-outs. There is ample basis for this assumption from the following considerations.

First, the clinic offers long-term therapy to patients; some have been in treatment two years and longer. Second, the staff views the problems of most patients as chronic and "deep," requiring extensive treatment for optimum result. Third, it would be very exceptional for a therapist to *recommend* termination before four months of treatment.

In Table 2 the data are presented in a form which shows the proportion of patients remaining in treatment for ever-longer durations. Of the patients to whom treatment was offered, 74 per cent came for the first treatment appointment. In other words, 26 per cent *failed* to come for even one treatment hour, although they had completed their initial evaluations and were assigned to treatment. Of the original group of 299 patients, 30 per cent terminated treatment after the second or third appointment. There were 44 per cent who remained in treatment for four or more appointments. Thereafter, the gradient of departure dropped less sharply. In the five appointments from the fourth through the eighth, an additional 14 per cent of the patients departed. This leaves a "survivorship" of 30 per cent. In the next five appointments, from the ninth through the thirteenth, an additional 8 per cent of the patients departed. In the next seven appointments, from the fourteenth through the twentieth, an additional 6 per cent terminated treatment. All these percentage figures are in terms of the *original* base of 299 patients.

For every six patients *offered* treatment, only one remained for 21 appointments (100 per cent: 16 per cent). For every nine pa-

tients who *accepted* treatment to the extent of coming the first time, only two remained for 21 appointments (74 per cent: 16 per cent).

C. Type of Treatment and Drop-Out

Group therapy is the predominant type of treatment at the clinic. A minority of patients, however, receive individual psychotherapy. Of the 299 patients offered treatment, 17 per cent received individual therapy; 83 per cent received group therapy. In the authors' attempt to account for drop-out rates, the obvious possibility that the type of treatment was related to drop-out presented itself. For two reasons it was thought that a higher earlier drop-out would be found among group patients. First, patients assigned to group therapy frequently voice dissatisfaction. They say that they had hoped to have individual therapy. Second, the study by Nash and associates found that the drop-out rate for group therapy was significantly higher than for individual therapy.[5] Of their group patients, 57 per cent dropped out in three or fewer sessions, compared with only 17 per cent in individual treatment. Their study was conducted in a setting, and with a patient body, similar to that of the authors.

Table 3 represents drop-out figures from the present study, categorized by type of therapy. It is seen that group therapy had less initial attractive power than individual therapy. Of the individual therapy patients, 84 per cent came for the first appointment, compared with 72 per cent of the group patients. By the fourteenth appointment, however, the differential had vanished. After 20 appointments, group therapy had slightly superior holding power.

Table 3. Percentages of Patients Remaining in Treatment for Specified Periods, by Type of Treatment

Type of treatment	Number of Treatment Sessions				
	1 or more	4 or more	9 or more	14 or more	21 or more
	Per cent	Per cent	Per cent	Per cent	Per cent
Group (250)* Psychotherapy	72	42	29	22	17
Individual (49) Psychotherapy ..	84	55	33	22	12
Total (299)	74	44	30	22	16

*Total number of group psychotherapy patients (N equals 100 per cent)

In subsequent percentage tables, the numbers in parentheses always refer to the numbers of patients upon which the percentages are based.

Table 4 allocates the patients into two categories: those who came less than four sessions, and those who came more than 13 sessions.* The χ^2 test for association between duration and type of treatment shows a nonsignificant result.

This result is in striking contrast to the study by Nash and associates, which found a difference significant at the 2 per cent level. Nash's explanation of their findings is: "Since group therapy was more stressful than the individual method (of therapy) used in this study, it might be expected that factors influencing patients to drop out of individual treatment would operate more strongly with respect to the group form."[6]

Differences in technical approach to group psychotherapy perhaps account for the difference in findings. At the Boston Evening Clinic, an approach based on ego theory is used for the patients, who suffer predominantly from personality disorders, chronic depressions, or ambulatory schizophrenia.[7-10] This approach involves purposeful activity by the therapist to facilitate corrective interpersonal experience for each patient, both with the therapist and with the other group members. Clarification, confrontation, suggestion, and sharing of feelings are used by the therapist *to keep the stresses manageable* and to support the mature ego in its *coping* aspects as well as in the development of insight. The anxiety tolerance and frustration-bearing capacities of these types

Table 4. Comparison of "Early" Drop-outs and "Late" Remainders by Type of Treatment

Type of Treatment	Numbers of Patients in Treatment Sessions		
	Less Than 4 sessions	More Than 13 sessions	Total
	No.	No.	No.
Group	145	54	199
Individual	22	11	33
Total	167	65	232

χ^2=.541
D.F.=1
.50>p>.30

*Patients who terminated treatment *between* four and 13 sessions (including the end-points of the interval) are not counted in this table. The aim here is to contrast the "extremes" only.

of patients are low. The authors agree, therefore, with Nash that drop-out is probably related to stress of therapy. It is suggested that the divergent results are in part due to the difference in group treatment methods.

Another factor of possible significance is the relative valuation of group therapy in the two clinics. The ultimate position of group therapy in the over-all therapeutic program of the Boston Evening Clinic is a question needing further scrutiny and evaluation. However, group therapy is viewed as having high potential for effective treatment of several problem syndromes, rather than as a "second-best" treatment method whose main virtue is that it can reach large numbers of patients.

The writers do not know the position occupied by group therapy in the hierarchy of staff values in the Nash clinic. Some indication that group therapy was viewed as "second-best" may be inferred from their discovery that, despite explicit instructions to the staff to place incoming patients randomly into group and individual treatment (as part of a research design), a disproportionately large number of "lower class" patients were nevertheless assigned to group therapy.[11] If, indeed, staff members in their clinic regarded group therapy as an ineffective or inappropriate means of treatment, this condition might in itself lead to heightened drop-out rates.

D. Diagnosis and Drop-Out

The second variable investigated for its relation to drop-out was diagnosis. Patients diagnosed as having neurotic anxiety or neurotic depressive reactions have, in previous studies, been found to be more likely than others to *remain* in treatment. Several studies have also used clinical ratings, or test scores on selected personality traits and abilities, as drop-out predictors. In these studies, psychopathy and nomadism have been found to be associated with early drop-out. Suggestibility, dependency, and high verbal skill have been found to be associated with staying in treatment.

Table 5 shows the relation of diagnosis to drop-out among Boston Evening Clinic patients. The patients are classified by gross diagnostic categories—psychotic, neurotic, and personality disorder. The reason for this crudeness is that the case folders for many patients did not contain more specific information. Indeed,

Table 5. Percentages of All Patients Remaining in Treatment for Specified Periods, by Diagnosis

Diagnosis	Number of Treatment Sessions				
	1 or more	4 or more	9 or more	14 or more	21 or more
	Per cent	Per cent	Per cent	Per cent	Per cent
Personality Disorder (137) ...	74	47	31	23	17
Neurotic (79)	73	39	24	20	13
Psychotic (28)	75	36	36	18	18
Unknown (55)	73	49	33	24	20
Total (299)	74	44	30	22	16

55 of the 299 patients are listed as "unknown" diagnosis, because not even a gross diagnostic judgment was available.

It will be noted that the modal diagnostic category for the Boston patients is "personality disorder." Within this category, a preponderance of patients have the specific diagnosis of personality trait disturbance, passive-aggressive personality.

Table 5 shows virtually no difference between diagnostic categories with respect to appearing for the first appointment. In subsequent ranges of treatment, minor differences appear between categories. None, however, holds up consistently over the whole range of treatment covered.

E. Role of Social Status

The third major variable whose influence upon drop-out was investigated is the social status of the patient. Social status of patients has been shown to be related to a wide variety of treatment processes inside and outside of mental hospitals. The Myers-Schaffer study may be taken as a representative study. It shows that "higher class" patients at a clinic (1) are more likely to be accepted for treatment; (2) are assigned to more experienced therapists; (3) receive longer treatment, and (4) receive more intensive treatment.[12]

In the authors' examination of the role of the patients' social status at the Boston clinic, the discussion will start with their first coming to the clinic. Where possible, comparisons will be made with the experience of the New Haven clinic, as reported by Meyers and Shaffer. The two clinics are much alike in aims and policies. The following excerpts describing the New Haven

clinic will bring out basic similarities. "The institution is a training and community clinic where treatment is oriented around expressive psychotherapy—it requires relatively long and intensive contact between patient and therapist. Anyone with an income under $5,000 [1950-51] a year and residing within a given geographic area is eligible for our care, and the fees charged are nominal and scaled."[13] One obvious *difference* between the two clinics is that group therapy, so abundantly used in the Boston clinic, is completely absent in the New Haven clinic. Also, the Boston clinic does not limit its geographic service area. Further, the Boston clinic requires that patients have full-time jobs, whereas the New Haven clinic does not. Despite these differences, relevant comparisons are possible.

Table 6 compares the social class of all admissions to the two clinics.* For the New Haven clinic, the time period covered is one year; for the Boston clinic, two and one-half years.

The following differences between the two clinics can be seen. The Boston clinic has relatively more patients in Classes I and II, although the difference is minor. In Class III there is a sizable difference. Almost half the Boston patients are from Class III, whereas little more than one-quarter of the New Haven patients are from this class. In Classes IV and V, the situation is reversed. The New Haven clinic receives relatively more patients from the bottom of the social hierarchy than the Boston clinic. In Class V, the disparity is especially large, 23 per cent in New Haven against 13 per cent in Boston.

In both clinics, there is a large gap between the initial presentation of patients and those eventually assigned to treatment. The New Haven clinic assigns 63 per cent of the initial bloc of patients to treatment; the Boston clinic, 48 per cent. Both clinics refer patients elsewhere, but this is a much more frequent practice

*Social class is determined in both studies by procedures developed by Hollingshead.[14] Class I comprises those families of highest status in the community. Most of its adult members have had education beyond the college level. Adult males hold top-level executive and professional positions. Class II comprises persons with college educations and respected, but lesser, occupational positions. Class III contains predominantly persons with high school or part-college education, located occupationally in the lower reaches of white collar work. A number of skilled blue collar workers are also found in Class III. Class IV contains persons with less than high school education and semi-skilled jobs. Class V, the lowest status class, contains many persons with, at most, primary school education, holding unskilled, often transient, jobs. Many Class V persons have long stretches of unemployment.

Table 6. Percentages of Clinic Patients Initially Seen at Two Clinics, by Social Class

Social Class	Location	
	Boston	New Haven
	N=600*	N=195
	Per cent	Per cent
I and II	12	9
III	47	28
IV	28	39
V	13	23
Total	100	99

*Thirty-three patients of undetermined social status are eliminated from the Boston total, reducing the size of the study group from 633 (Table 1) to 600.

in the Boston clinic. Both clinics also report large numbers of patients for whom no disposition is made. However, there is an important difference in the nature of "no disposition." In Boston, this most often means that the patient failed to complete his initial evaluation. Hence the staff could make no disposition. In New Haven, where the initial evaluation was a briefer process, there are no data about "incompletes." However, it is known that the staff, using its professional judgment, decided in many cases not to recommend any treatment. The meaning of this decision is not clarified in the Myers-Schaffer report. This type of decision is rather rare at the Boston clinic. Virtually every patient who completed initial evaluation was either referred elsewhere or assigned to treatment at the clinic.

Having compared *initially-seen* patients at the two clinics, one may look at Table 7, which compares *treatment* patients. In many respects, this comparison parallels the preceding one. However, some important differences are to be noted. First, the New Haven clinic treats more high status patients—those in Classes I and II —than the Boston clinic. The Boston clinic has a relatively larger share of Class III patients, whereas the New Haven clinic has a relatively larger share of Class IV patients. Both clinics offer treatment to about the same proportion of Class V patients.

Tables 6 and 7 compare the patient populations at two points in time: (1) the patient's initial interview in the clinic, and (2) the patient's acceptance for treatment. Each of these tables thus makes a "static" comparison.

Table 7. Percentages of Clinic Patients Offered Treatment at Two Clinics, by Social Class

Social Class	Location	
	Boston	New Haven
	N=292*	N=114
	Per cent	Per cent
I and II	7	10
III	51	33
IV	31	45
V	11	12
Total	100	100

*Seven treatment patients of undetermined social status have been eliminated, reducing the Boston treatment group from 299 (Table 2) to 292.

The patient's passage from initial interview into treatment is an aspect of *process* in the clinic. One may inquire also about the role of social class in this process. For instance, in the Boston clinic, 13 per cent of all *patients initially seen* are Class V, and 11 per cent of all *treatment patients* are from Class V. Thus, Class V, in moving from initial evaluation to treatment, decreased its share of the total. There is a slight loss of Class V patients. The corresponding figures for the New Haven clinic are 23 per cent and 12 per cent, respectively. The attrition of Class V patients is much greater in the New Haven clinic. Pursuing these comparisons systematically, one sees that, in both clinics, the proportion of Class III patients remains fairly level through this process. The same conclusion holds also for Class IV. At the upper end of the class continuum, the New Haven clinic slightly *increases* through time, the proportions of Class I and II patients (represented by the percentage ratio of 9:10). The Boston clinic substantially *reduces*, over this time, the proportions of Class I and II patients (12:7).

These points of contrast in the operation of the two clinics are difficult to account for. However, it is known that, at the Boston clinic, many "higher class" patients are referred elsewhere because their incomes exceed the clinic income limit. This is the major factor behind the substantial reduction of the Class I and II contingent in the movement from intake to treatment. The striking reduction, in New Haven, of Class V patients is due largely to the fact that this clinic frequently makes no treatment recommendation for these patients.

Another important parameter of clinic functioning is *the selection of patients for different types of treatment.* The Myers-Schaffer article reports a strong relationship between social class of the patient and the degree of the therapist's experience.[15] Higher class patients received treatment from senior staff members, whereas lower class patients were assigned for treatment to relatively inexperienced medical and psychology students. This difference is a statistically significant trend, of course, rather than an absolute differential. This finding, however, buttresses the *general* hypothesis of the New Haven study: that the social status of patients has important consequences for their psychiatric "fates."

The New Haven study offers only individual therapy, whereas the Boston clinic offers both individual and group therapy, with heavy emphasis on the latter. This discrepancy in the treatment programs of the two clinics makes direct comparison of social class effects impossible. However, an indirect comparison is possible.

At the Boston clinic, an appropriate way of investigating the effect of class upon treatment assignment is to look at the allocation of patients into group and individual therapy. Individual therapy requires the therapist to devote his attention to a single patient, while group therapy divides and alternates his attention among several patients simultaneously.* If the social class of the patient is influential in treatment allocations, one would expect higher class patients to be favored for individual therapy. Particularly in view of the relative scarcity of individual therapy at the Boston clinic, one would expect very few lower class patients to receive it.

Table 8 tests this hypothesis. It shows clearly that social class exerts no *systematic* influence upon type of treatment. Patients in Classes I-II and V are seen in individual therapy in almost the exact proportions of their bulk in the total treatment population. Class III is underrepresented for individual therapy (hence, overrepresented for group therapy). Class IV has more than its pro-

*Patients in group therapy often feel that the therapist's attention is "scarce," since it must be shared with other patients. This feeling leads to such piquant cogencies as the following. A patient says, "This treatment hour is costing me four dollars. There are ten patients in the group and the session lasts 50 minutes. So I get five minutes of the doctor's time, and that's what my four dollars is going for... so this is really costing me $48 an hour..."

Table 8. Selection of Patients for Individual and Group Therapy, Boston Clinic

Social Class	All Treatment Patients		Individual Treatment Patients		Group Therapy Patients	
	No.	Per cent	No.	Per cent	No.	Per cent
I and II	20	7	4	8	16	7
III	148	51	19	40	129	53
IV	91	31	20	42	71	29
V	33	11	5	10	28	11
Total	292	100	48	100	244	100

portional share of individual therapy. These variations do not, however, testify to a *consistent* social class effect.

Having investigated the relationship between social class and type of treatment, one may now consider the effects of social class upon *duration* of treatment. Here the primary concern will be exploring this relationship in the Boston clinic, supplemented by comparisons with the New Haven study.

In Table 9, the proportions of patients from different classes who remained for given numbers of treatment sessions are compared.* It is to be noted first that the New Haven clinic had greater

Table 9. Comparison of Treatment "Remainers" in Two Clinics

	Boston	New Haven
	Percentage in Social Class Seen 9 or More Times	Percentage in Social Class Seen 10 or More Times
Social Class	Per cent	Per cent
I and II	50	75
III	32	63
IV	26	30
V	18	29
Total	30	46
	Boston	New Haven
X^2 for remainers versus drop-outs by social class:	9.28	15.44
D. F.	3	3
Probability	>.05	>.01

*The data are not exactly comparable, because the Boston tabulations show the percentage seen *nine* or more times, and the New Haven tabulations the percentage seen *ten* or more times. However, as the data show, this minor lack of correspondence is no bar to relevant interpretations.

success in holding patients *at all class levels* than the Boston clinic. Of the New Haven patients, 46 per cent are in treatment for at least 10 sessions. Only 30 per cent of the Boston patients remained for nine or more appointments. The superior "holding power" of the New Haven clinic is probably due to a more selective screening of patients for treatment. It is surmised that many New Haven patients who *would,* if offered treatment, drop out early, are not recommended for treatment, whereas the Boston clinic, operating less selectively, admits such patients to treatment and *then* experiences a higher rate of drop-out.

What does Table 9 tell about the strength of social class as a determiner of drop-out?

One sees that the social class gradient is in the expected direction at both clinics: the higher the social status, the higher the proportion of patients remaining in treatment. This class variation in drop-out is statistically significant at both clinics, taken independently: χ^2, comparing frequency of remainers with social class in New Haven, has a probability of less than .01. For Boston, the corresponding probability is less than .05.

Now, the effect of social class over a *wider* span of treatment duration will be considered. Table 10 shows percentages of patients remaining in treatment at several points, up to 21 sessions. These data apply to the *Boston clinic only.* Comparable data are not available for the New Haven clinic.

Table 10 shows that, at different stages of therapy, higher status patients are more prone to remain in treatment. Correspondingly, drop-out is higher among patients of lower social status. Although Table 10 in general conforms to this rule, there are specific features

Table 10. Percentages of All Patients Remaining in Treatment for Specified Periods, by Social Class

Social Class	Number of Treatment Sessions				
	1 or More	4 or More	9 or More	14 or More	21 or More
	Per cent	Per cent	Per cent	Per cent	Per cent
I and II (20)	75	65	50	35	30
III (148)	78	45	32	24	20
IV (91)	69	41	26	19	11
V (33)	70	36	18	15	9
	—	—	—	—	—
Total (292)	74	44	30	22	16

that require attention. At the outset, there is not much variation among the social classes. Of *all* patients, 74 per cent accept therapy to the extent of coming at least once; figures for each class do not greatly deviate from this general level. But at later stages of treatment, the class variation in percentages remaining becomes increasingly marked. By the twenty-first appointment, over three times as many Class I and II patients remain in treatment as Class V patients (30:9).

Having obtained statistically significant discrimination (p less than .05) for drop-outs versus remainers at the nine-week level, the relationship may be tested again for the broader span of treatment durations. The numerical data are presented in Table 11. This table shows *numbers* (not percentages) of patients who "survived" for increasing lengths of therapy. It is from this frequency table that the percentages of Table 10 are generated.

χ^2 for Table 11 has a .20 level of probability. This indicates a trend, but not a binding relationship between class and drop-out. Obviously, the vitiated effect of social class at the *beginning* of treatment has served to weaken the *over-all* relationship. Thus, while social class is an important factor in drop-out, care is essential in describing its mode of influence.

One correct way of formulating the findings is this. At the Boston clinic, there is a high level of drop-out. Large contingents of patients leave treatment at each successive stage. There is, how-

Table 11. Duration of Treatment by Social Class, for Group and Individual Patients Combined

Social Class	Number of Treatment Sessions						
	0	1-3	4-8	9-13	14-20	21 or More	Total
	No.	No.	No.	No.	No.	No.	No.
I and II .	5	2	3	3	1	6	20
III	32	49	19	13	6	29	148
IV	28	26	13	7	7	10	91
V	10	11	6	1	2	3	33
Total	75	88	41	24	16	48	292

χ^2=21.59
D. F=15
.20>p>.10

ever, a relative decline in the propensity to drop out as a patient moves further along in treatment.

In the early stages of treatment, when drop-out is highest, social class is not related to drop-out. As treatment progresses, a social class differential emerges. Patients with higher social status remain longer in treatment than those with lower social status. At subsequent stages of treatment, social class exerts an ever stronger influence.

Summary and Discussion

Drop-out rates in out-patient psychotherapy have been studied, using a group of patients from a Boston clinic. The data confirm the experience of other clinics. At every point along the path from initial contact into treatment, sizable contingents of patients fall away. Drop-out rates are heaviest at early points of contact.

Possible causes of drop-out were explored. It was found that type of treatment—group psychotherapy or individual psychotherapy—is unrelated to drop-out rates. This finding was examined in relation to a Baltimore study which found higher drop-out rates among group therapy patients.

The writers found no consistent relationship between diagnosis and drop-out.

The role of social class of patients in relation to drop-out, and also in relation to other parameters of clinic functioning, was also investigated. Data were presented showing the class composition of the clinic's intake population, and of its treatment population. Social class was found to be unrelated to allocation of patients into individual and group therapy. This finding is important because it stands at variance with other studies which report that a patient's social class has a marked influence on the type of psychiatric treatment he receives.

The examination of the role of social class in drop-out showed that higher class patients tend to remain longer in treatment than lower class patients. This relationship, while consistent with research findings in other settings, is not statistically strong. The Boston clinic findings indicate that social class becomes important only as treatment progresses. At the outset of treatment, the class differences are slight.

What are the implications of drop-out for psychiatric practice? Drop-out is a massive phenomenon. Yet it has been largely ignored

in professional discussion. It is understandable that this should be so. Drop-out, as a matter of quantifiable behavior, is expressed in *rates*. Rates are attributes of populations or collective units. Drop-out rates find no meaningful niche in the discussion of patients' *individual dynamics*. Further, clinics are crowded nowadays. If many patients drop out of treatment, many more will take their place.

The writers feel, however, that drop-out deserves more attention than it has received. In a period of heavy demand for psychiatric services, it behooves mental health planners and policy-makers to think about the efficient use of resources. On every side, experts proclaim the need for more psychiatrists, and more treatment facilities. As part of this trend, there is a growing emphasis upon the establishment of out-patient clinics oriented to the mental health needs of the local community.

In view of the present findings, and those of other studies, the writers ask these questions. What use will communities make of expanded out-patient facilities? Will the public—or rather, the emotionally disturbed portion of it—use treatment facilities in the intended way? Or, as the present research leads one to predict, will the bulk of applicants for treatment approach the clinic, only then to make a hasty retreat? What account shall be taken of drop-out, in assessing community needs for service?

Drop-out also poses many problems of sociological interest. The practical questions about wise planning for new psychiatric facilities reflect issues in the larger cultural setting of psychiatric practice. A single aspect of this will be briefly considered, the relation of drop-out to public attitudes toward psychiatry.

During the last decade, the public has learned much about mental health. It has been educated in the desirability of professional help with emotional problems, in various mechanisms of psychic functioning, in sound child-rearing methods, and the like. Models of good personality adjustment are identified and valued. The practitioners of amateur diagnosis thrive and abound. Psychiatric concepts and values, particularly those surrounding psychotherapy and psychoanalysis, have deeply penetrated influential sectors of urban culture. This penetration has occurred most directly through the increasing use of therapists and counselors in institutions such as factories, schools, prisons, courts, and military establishments. The mass media have also provided much education.

What is the bearing of this general trend upon drop-out? It is suggested here, speculatively, that this new emphasis has two broad effects.

First, it has effectively dispelled antique notions of mental illness and has, in general, conferred a new legitimacy upon the discussion of emotional problems. The barriers to seeking psychiatric help have been lowered. The demand for psychiatric services has correspondingly increased.

Second, this trend has tended to idealize and over-sell psychiatry. This leads to high drop-out. Ill persons, who 20 years ago would have avoided a psychiatrist at all costs, now seek him out—in high hopes of the quick and easy cure so often dramatized in the films. Disappointment is inevitable. Other persons, less fraught with specific symptoms but suffering rather from various malaises, may turn to psychiatry for a sense of coherence and meaning in life. These persons, even if relatively sophisticated in their understanding of treatment, may experience disappointment too. Their diffuse quest for personal purpose conflicts with the therapist's typically instrumental conception of therapy as a means for the resolution of specific problems.

In conclusion, two aspects of drop-out that have not been discussed in this research should be briefly noted. These are: the matter of the individual motivations leading patients to drop out of treatment; and (2) the effect of drop-out. Study in the areas would be important, it is felt, in defining the senses in which drop-out *is* a problem. One knows on a sheer statistical basis that drop-out is a broadly prevalent *phenomenon*. The writers think it is also a *problem*. After all, the staff's expectation that patients will continue in treatment is frustrated. Clinic resources for the initial evaluation of the patient are wasted if he does not continue in treatment. Most important, many patients who need treatment do not remain to receive its benefits.

But one dares not assume too much. Certainly it can be said, this issue deserves investigation. At the Boston clinic, the writers are interviewing some patients who have dropped out of treatment. These interviews will, it is hoped, shed light upon the significance of drop-out. If, indeed, the fact emerges that most drop-out patients function well and have lost presenting symptoms, then the usual staff view that long-term treatment is necessary should be modified. Perhaps some revisions of our conception of treat-

ment needs are in order. But, if it develops that, for most patients, drop-out means defeat, frustration, and the chronic repetition of emotional difficulties, then serious concern must be brought to bear upon the question of how to *reduce* drop-outs.

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PANTS, POLITICS, POSTAGE, AND PHYSIC

BY JAMES A. BRUSSEL, M.D.

One need not be a psychiatrist to differentiate psychotic behavior from normal comportment. Frequently, however, even the alienist experiences difficulty in gauging the "bizarre," the "sensational," the "peculiar." Sarah Bernhardt's habit of sleeping in a fur-lined coffin was regarded as eccentric but not an indication of a disordered mind. Historical annals are replete with similar examples.

What of Mary Edwards Walker, attired in trousers, and aggressively masculine to the point of becoming the first female medical officer in the American army? Although she can be considered almost a contemporary, so many legends have arisen about her that she has, in the brief space of 40 years since her death, become an American myth.

Mary Walker was no frightening freak of nature; she was not afflicted with glandular dysfunction or anatomical defect. In fact, her colleagues, friends, and biographers agree that this pioneer in feminine medicine was all woman—dainty, petite, and shapely. Nor was there anything in her background to account for her odd and unusual mannerisms. Among her ancestors were signers of the Mayflower Pact, including the eminent Elder Brewster. Mary's forebears walked in the light of the Lord, were sober, energetic, steady pioneers who, down through succeeding generations, followed the uncharted path from grim and cold New England to western New York. Mary's parents were staunch advocates of education and more education. They had been teachers; Mr. Walker had studied medicine for a brief period. In western New York's virgin territory, he and his wife answered their neighbors' call for a school by donating a tract of land on which the first one could be erected. The faculty consisted of Mrs. Walker and her older daughters. The fifth female child of the Walker household first saw the light of day at Oswego on November 26, 1832. This addition apparently prompted Mr. Walker to take further steps to guarantee a liberal education for his family. He mortgaged his farm land, making it possible for the children to attend the highly esteemed Falley Seminary at Fulton, only 12 miles to the southeast. Under Methodist tutelage, this institution had won for itself an enviable reputation.

Biographers uniformly report that Mary, from her earliest days, was obsessed with the idea of becoming a physician. The healing art was then practised by men; no woman had ever been granted a degree in medicine. However, the child was very determined and not easily discouraged. Her doggedness and keen intelligence rendered her responsive to a medical missionary who urged women to study medicine and serve as doctors of God. This started her on the road she was to travel for the next 75 years. Hungrily she searched for anything that could be linked to her chosen field. She pored over coroners' reports, autopsy findings, and what professional records she could discover. She became a ready attendant at sickbeds, to observe symptoms at first hand. Scorning the family physician's derisive gibes, she borrowed his textbooks and read them again and again. Neighbors and friends poked fun at her, but she learned to ignore this at an early age; for the rest of her long life, she was immune to taunts.

Like her sisters, Mary attended Falley. The study of anatomy was an elective rather than a required course there; and the first day she walked into the anatomy classroom, the male students rose from their chairs and stalked out. The Walker family was not prosperous, so Mary alternated semesters of learning with semesters of teaching. She hoarded her meager pay for greater goals. In her search for medical education, it is interesting to note that about the only ones who offered no objection—in fact, they encouraged the girl—were her parents! Gaining admission into a medical school in pre-Civil War days was, for a young woman, easier said than done. The religious society agreed to finance her postgraduate education if she would sign up for missionary work. Mary rejected this offer, because she felt that she could do more for her sex in the United States where women were then judged by their culinary and reproductive capacities.

In 1849, Elizabeth Blackwell became the first female physician in America, upon graduation from Hobart College in Geneva, N. Y. Apparently the ridicule and scorn heaped upon that staid institution influenced the authorities to refuse Mary Walker admission to study medicine—a case of once bitten, twice shy. Fortunately, however, the dawn of scientific progress brightened the horizon of Syracuse. Here, in 1851, through the intervention of Séguin, the French medico-political refugee, the first school for the feebleminded in New York State had opened. Here, too, a charter had

been granted to Syracuse Medical College which was not part of Syracuse University. This eclectic professional school lasted long enough for Mary Walker and several other determined and far-sighted women to work for their coveted sheepskins. However, in 1855, at the final commencement exercises only two students who had weathered examinations received degrees. They were Dr. Mary Walker and her future husband, Dr. Albert E. Miller!

Whenever the finger of heterosexual maladjustment is leveled at the girl from Oswego, defenders proudly point to the marital union that had resulted from an undramatic courtship conducted in classroom and laboratory. Mary's champions—and there were and are many—declare that the marriage was ultimately wrecked because Dr. Miller never understood his wife and was intolerant of her "whims." Certainly she burned with a constant desire to lead, to blaze the trail, to dominate. She cared naught that she lied, deceived, resorted to subterfuge, made herself a public spectacle, and courted scorn and ridicule with her outlandish attire. Her reckless and driving personality is deftly described in a letter written by Captain Robert Bartholow, a Civil War surgeon with the Union forces. In his communication (1867) to the *New York Medical Journal* he says:

> ...and a great deal of confusion has arisen as to her real merits, her service in the army, and her position in the medical profession. As I have happened, in the way of official duty, to learn something from this woman, herself, I beg to put your readers in possession of my information. [Here the chronological account in this paper is sacrificed to continue the captain's letter.] My first observation of Dr. Mary Walker was made at Lincoln General Hospital, Washington, to which she came, in some pretended inspectorial capacity, armed with a pass from Secretary Stanton. The particular function intrusted to Mary Walker seemed to be that of spy and informer; at all events, she pretended to have power to obtain redress of grievances, and industriously set about hearing and contriving them. At this period, she was dressed in that hybrid costume which has since become so notorious.
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> My next encounter with Miss Walker was at Chattanooga. [Note that Mary had abandoned her spouse *and* his name!] She was sent out by the War Department, through Acting Surgeon-General Barnes, to Assistant Surgeon-General Wood, at Louisville. Dr. Wood, it is to be presumed, under instructions from Washington, sent her forward with orders to report to Surgeon Perin, Medical Director of the Army of the Cumberland. She presented herself to Dr. Perin and demanded employment as a Medical Officer. He was not a little astonished at the apparition, and, I may add—

I trust without damaging his reputation with the powers that be—indignant that the lives of sick and wounded men should be entrusted to such a medical monstrosity. Before assigning her to duty, which he resolved not to do, he ordered a medical board to examine into her qualifications, as a justification for his decision. I was a member of that Board. *Dr.* Walker presented herself for the examination, with a little feminine tremor and confusion, and before settling down to the graver business of the medical examination, tried to propitiate us and secure a favorable report, so that we might take it for granted she possessed the requisite knowledge. She betrayed such utter ignorance of any subject in the whole range of medical science, that we found it a difficult matter to conduct an examination. The Board unanimously reported that she had no more medical knowledge than any ordinary housewife, that she was, of course, entirely unfit for the position of medical officer, and that she might be made useful as a nurse in one of the hospitals.

During the examination, we learned various particulars of her history, which I forbear to mention. She had a diploma, she said—we did not see it—from a "hydropathic institution" at Geneva, N. Y. She had never been, so far as we could learn, within the walls of a medical college or hospital, for the purpose of obtaining a medical education. [Apparently Mary wanted to conceal the ignominy of being a graduate of a defunct eclectic school.]

The spectacle was both ludicrous and sad. Her pretension, her ignorance, her sex, her unprotected situation, all appealed strongly to our sympathies and we treated her with the utmost delicacy and consideration.

Later, the remainder of Captain Bartholow's interesting and revealing communication will be quoted. Let us return to Mary's time immediately following her graduation from Syracuse.

That her medical training was a diploma-mill, once-over-lightly affair cannot be doubted. One of her staunchest admirers and biographers, Mrs. Lida Poynter, carefully separates the group of female medical pioneers who lacked adequate educational advantages, such as Mary Walker, Lydia Hasbrouck, and Ellen Harman, from that illustrious squad of skilled and carefully trained women physicians that included the Blackwells, Mary Jacobi, and Hannah Longshore. Mary Walker's smattering of medical lore explains her scientific ignorance, which she tried to conceal behind a sharp and uncompromising tongue. This was evident, time after time, in her many *pronunciamentos.* As late as 1916 she wrote to the *Knickerbocker Press* to air her views on infantile paralysis. She angrily denied that poliomyelitis was contagious, damned quarantine, and, because children are stricken more often than

adults, attributed this age factor to the consumption of milk in which youngsters outdrink older persons, and to children's inability to throw off the poison of tobacco!

Her early years had been trying ones for Mary Walker. Harrassed by colleagues' coolness and disdain, and plagued by marital maladjustment, the situation called for the firm determination that only a paranoid and narcissistic mind could provide. She had hung her shingle in Columbus, Ohio for a fruitless and unremunerative twelvemonth. *That she had not yet been graduated* from medical school seemed of little consequence to her or the Ohio state authorities. She came home to Oswego on the shores of Lake Ontario in 1855 and in November of that year gained her diploma *and* a husband.

Dr. Miller and his wife established their bicameral practice in Rome, N. Y. where the female component of this menage apparently did not believe that one should do in Rome what the Romans do. Dr. Mary Walker Miller might have launched herself on a promising and successful career. Instead she concentrated her energies on activities which were regarded as nothing less than erratic. Dating from girlhood, when frustration of personal ambitions fanned emotional flames of insecurity, inadequacy, and inequality, she had yearned for parity with the male sex. The virus of Seneca Falls had infected her, and the first symptoms of the disease began to manifest themselves.

Seneca Falls, lying between the northern extremities of Cayuga and Seneca, two of the largest finger lakes in New York, has its counterpart in thousands of American hamlets. But no other rural community could boast of such feminists as the redoubtable Amelia Bloomer and the bellicose Elizabeth Cady Stanton. Amelia, celebrated in the lyrics and songs of *Bloomer Girl,* was the original exponent of pants-for-women (ergo, the term "bloomers"). Her neighbor, Elizabeth Stanton, carried the torch for bisexual suffrage. It was not the campaigns that captured Mary Walker, not the principles, not the isms, but the fiery, masculine, virile, militant spirit of kindred female souls. Here, then, was something too hot for most women to handle, something that the period considered exclusively for men. But it was not too torrid or mascuine for the Walkers, the Bloomers, and the Stantons.

The Rome era was not Mary's first attempt to incorporate maleness in her garb. As a young schoolteacher she had experimented

with skirt-covered trousers, and had tried varying lengths of skirts over and without pants while at medical school. Classmates scoffed at her and said she was lazy in the matter of personal laundry and that she sought publicity by exhibiting her limbs. It was this everlasting obsession with dress that laid the cornerstone for her marital disaster—and for her international and questionable notoriety. As a prominent moving spirit in the National Dress Reform (and a constant contributor to its journal, *The Sibyl*), it was a natural sequitur that the unblushing bride should march to the altar attired in trousers. The gasping audience could barely differentiate her from the crimson bridegroom who had violently and fruitlessly objected to his mate's indecent garb. Later, from 1877 to the day of her death almost a half century later, Mary Walker always dressed in male attire. Despite her many accomplishments she is best known for her unorthodox dress. At first she lectured on the subject of wardrobe. Very soon thereafter she began to orate on other topics from temperance to postal customs and politics.

No deep psychiatric analysis is needed to discover the etiology of her ruined married life. Perhaps Albert Miller could overlook his wife's distorted idea of comely feminine apparel; but he could not forgive the fact that, while she was supposed to concentrate her clinical efforts on gynecology and pediatrics, she too frequently ministered to male patients. She scathingly informed her husband she could do as she pleased because she had had the foresight to delete the verb "obey" from their marriage ceremony. She also arched eyebrows at his nonclinical penchant for women. He sneeringly retorted that she was no wife and never could be. She even signed herself as Dr. Mary E. Miller-Walker, refusing to surrender her name for his. In brief, her personality was unsuited to the task of placid and wifely domesticity. She simply had to be the dominant partner. It was Mary, not Albert, who finally pursued divorce proceedings. However, the husband and the law of the state thwarted her. In 1859, it was not Mary who hysterically packed a grip and fled to mother and home. It was Albert, whom the female doctor never saw again.

During the summer of 1860 Mary moved to Delhi, Iowa to establish a residence for the purpose of divorce. She was not content to sit and twiddle thumbs waiting for the papers that would forever free her from Albert. She enrolled at Bowen Collegiate In-

stitute, now known as Lennox Junior College. She wanted to study German and oratory; but the German teacher had enlisted in the Union army so the language was not taught; and women students were barred from classes in public speaking. Undaunted, Mary wormed herself into the men's debating society, and the college thereupon expelled her. In 1861 she returned to Rome long enough to close the Miller house and dispose of her belongings. She moved to Oswego where she began to toughen herself with many masochistic rituals such as sleeping on the bare floor which she regarded as *de rigueur* for her next and very bold step.

World War II veteran medicos who are wont to "gripe" about their arduous experiences and rough going, would do well to read the fantastic and colorful military career of Mary Walker who will go down in history as the first woman medical officer in America's army! At first she went from official to official in Washington; she dogged the "top brass," pestered influential government officers, camped in waiting rooms, but all to no avail. Finally, ever chafing at inactivity, she voluntarily worked in the Indiana Hospital in Washington where she apparently was a whirling efficient combination of physician, nurse, orderly, mail clerk, Red Cross worker, and social service investigator. She boldly visited the front, a matter of miles from the capital; she unofficially served as a transport surgeon on a train that carried wounded to New York. Here she took time out from wartime service to garner another phony M.D. degree, this time from the Hygeio-Therapeutic College. Also, on one of these self-imposed military missions she was arrested for walking the street in pants, the first of many such experiences that were to hound her throughout life.

With a sudden change of heart, the United States Army commissioned Mary Walker as a contract-surgeon in 1864. This reversal of policy seems strange until we learn, as we do in the rest of Captain Bartholow's letter, the reason behind the switch. This odd woman enjoyed her swashbuckling life, rejecting escorts, traveling behind the lines, toting two revolvers, roughing it, going without food and rest for long periods. Glory! What a token to the self, what a quenching cupful for thirsty egocentricity!

Writes Captain Bartholow:

> In a day or two after the examination [he refers to the board of inquiry that was previously mentioned] she was assigned to a hospital as nurse, but had not entered upon her duties, when an order came from Department

Headquarters, sending her to the extreme front! We learned, in a few days, that she was riding about the outposts, and when riding alone, one day, she ventured too far, and was captured and forwarded to Richmond, being treated with considerable rigor, notwithstanding her sex and her claim to the privileges of a medical officer.

It appeared subsequently that this was the design. She was intended as a spy, and went forward to be captured. It was supposed that her sex and *profession* [the italics are Bartholow's] would procure her greater liberties and wider opportunities for observation than were at all possible to other prisoners. The medical staff of the army was made blind for the execution of this profound piece of strategy by the War Office—another instance of the esteem in which medical officers were held by the Hon. Secretary of War.

At Richmond, Mary was clapped in the prison at Castle Thunder, because the ill-famed Libby prison had no private rooms. Local newspapers made great sport of the lady officer who suffered many indignities and hardships. In August, several weeks after her "capture," Dr. Walker was exchanged for a Confederate six-foot-tall medical officer from Tennessee. It is difficult to visualize what tactical information she brought back from a few months imprisonment. Certainly there is no record of lurid experiences one might expect at a time when feminine company was scarce in the military, and in a woman whom partial historians describe as "beautiful, with a fine complexion, sparkling eyes and a profusion of dark curls. She was very small, only a little over five feet tall, well rounded ... and until she was well along in years, her pictures show her to have been a handsome woman." Obviously, "Barkus wasn't willin'," and those who came in contact with her quickly appreciated that concupiscence was not her weakness—or forte.

In June 1865 Mary was separated from service and became the only woman in history to receive the coveted Medal of Honor from Congress. Like every G.I., she was faced with the problem of postwar readjustment. Restless, lacking a love object, and with no outlet for a wild, reckless energy, she drifted from one pursuit to another without success. Journalism, the study of law, writing, and serving as adviser to veterans, all left her unsatisfied and feeling insecure. To top that off, was the odious divorce decree that Albert Miller obtained in New York in 1866. Escape was the only answer. So, with St. Louis' Dr. Susannah W. Dodds, she sailed for England. She was in time for the annual meeting of the Society

for the Promotion of Social Science. At this convention she aired her views on infanticide, capital punishment, woman suffrage, and, of course, dress reform. To say the least, she whetted the appetite of the curious and provoked much comment during this time. On this, the *New York Medical Journal* gleefully reports in 1867:

Dr. Mary Walker of this city is creating a heavy sensation in London, but her experience there, we judge, will not prove among the sweetest of the "pleasures of memory," nor will they tend either to advance the cause of which she has voluntarily assumed the championship or add greatly to her individual reputation. We gather from the English journalists the following notices of her appearances as a lecturer in St. James Hall. Her subject was "The experiences of a female physician in college, private practice, and in the Federal Army."

"The audience was of a very mixed description, the greater portion being evidently actuated by curiosity to see and hear the lectures, whilst a certain section, which mainly occupied the upper gallery, was as evidently bent upon getting the greatest possible amount of fun out of the proceedings. To beguile the tedium incident upon a little delay which took place ere the lady appeared, this compact body chanted with stentorian voices the Federal army chorus:

'Glory, glory, allelulia,
As we go marching on.'

Any slight monotony which the constant repetition of this war song might have created was avoided by interspersing it with 'Rule Britannia,' and the more familiar but less refined, 'Slap, bang!' Her dress was a long dark cloth tunic, reaching nearly to the knees, fitting closely to the figure above and expanding below, open to a certain extent in front, so as to disclose an inner garment, which we dare not attempt to name, but which served the purpose of a waistcoat, and carried a watch and chain disposed as is usual among men. Dark trousers ('pantalettes,' she called them) and boots like those ordinarily worn by the male sex completed the essentials of her costume. She had, besides, a light wreath of dark green leaves upon her hair, a turn-down collar and neckerchief, whilst shirt-wristbands peeped from her sleeves and partially concealed the white kid gloves upon her hands. She wore an order given her by the United States Government. She described her own costume as a 'psychological dress with moral bearings' (taken, we presume, from the shoulder down). We cannot say much for her lecture. The early part was as prosy as anything we had the ill fortune to hear in our student days. The description of the obstacles she met with in her course of study chiefly harped upon one string, dress. Indeed this essentially feminine trait disclosed itself throughout her discourse. One could discern the tone of a woman in whom an otherwise laudable desire for a convenient and reasonable costume was swallowed

up by the little feminine vanity which accompanies singularity. And so there was enough talk of short petticoats, pantalettes, and ankles to cause considerable surprise among the female portion of the auditory, as yet unaccustomed to the 'go-a-headness' of our Yankee cousins. The lecture was an undertaking altogether above her powers, and its only result has been to throw ridicule on herself, her sex, her profession, and her country, and to strengthen the opinions of those who hold that woman had better not meddle with physic."

Another periodical—the *New York Medical Journal* reported—wrote, in describing the lecture:

"As a composition, it was an entire failure, and clearly had never been revised by any educated gentleman before delivery. It professed to be an account of the Doctor's experience at college, in private practice, and in the army; but so far as actual facts, anecdotes, or descriptions were concerned, it was meagre and unsatisfactory to the utmost. Self-consciousness, or vanity, or egotism, call it what you will, and that of an unmistakable feminine order, gave the predominating key-note to the address. Let the topic be what it might, college, practice, or military adventure, the speaker involuntarily brought in the subject of dress, and this not merely in its physical and objective bearings, but also in their delicate subjective relations, to which the mind of even a female physician is shown not to be insensible. The Doctor's evident consciousness of sex was one of the characters which contributed to make the entertainment painfully ridiculous. In thus speaking freely of this melancholy exhibition, we do not forget that a female physician is one thing, a female lecturer another. If a woman choose physic as a vocation, and follow it through its wearisome and disgusting studies, we respect if we do not commend her, and certainly no word of ours shall tend to deprive any female physician of her claim to unprejudiced trial. If women are clearly not fit to practice physic, the race must die out; if they are, let them. It may be a mistake, but it is no business of ours. To come forward as an orator in a public hall is quite another thing. Dr. Mary Walker's entertainment, apart from the interest which the presence and costume of the lecturer created, was vapid and thin, showed no intellectual grasp or solid foundation, and when it was enriched with a bit of the pathetic or sublime, threw the auditory into convulsive shrieks of laughter. It was listened to with contemptuous good nature, intermixed with occasional unmannerly interruptions from a gallery said to be filled with medical students, and with an ironical cheer at its close. The Doctor may be consoled by reflecting that if she had been a man, the whole thing would have been unequivocally damned in five minutes and the room in an uproar. The interruptions and jocularities she experienced were not an insult to her sex, but to her capabilities as a public lecturer."

The *New York Medical Journal* also reports that the *Medical Press and Circular,* with a bitterness and intensity of satire surpassed only by its coarseness, styled her the American Medical Nondescript, and suggested as a subject for her public entertainments: "Why Not? or, Clitoridectomy and its Uses"!

Despite these official adverse medical press notices, her biographer, Mrs. Poynter, insists Mary Walker had phenomenal success as a lecturer in Great Britain. In London she delivered 30 addresses which earned her a private audience with the Good Queen. Mary, incidentally, showed up at this regal function in her reform garb, to the consternation and horror of all court personnel except, apparently, Queen Victoria.

Her flagging ego fortified by her European success (sic!), Mary sailed in a gay and determined mood for American, eager to reveal the details of her foreign conquests. In fact, she derived enough strength from this invigorating jaunt to institute several lawsuits. Now the paranoiac was revealed in litigious compensation for inner inferiority which Mrs. Poynter gracefully and apologetically dismisses as a time that "almost unhinged her mind for a few years. . ." Mary Walker sued Albert Miller, her matrimonial nemesis; she plagued the New York State Legislature for separate and privileged legalization of her masculine attire; she pestered Congress and the War Department to compensate her for various expenditures made while in the military service and for back pay allegedly never received.

These legal flings and international tries at various (male) pursuits were unsuccessful attempts to obfuscate the failure to achieve her goal of life, a successful medical career. Dr. Brown-Séquard probably holds the fictitious world's record for opening and closing offices and the taking and relinquishing of medical appointments, interspersed with over 60 trans-Atlantic voyages, but this eminent neurophysiologist was materially successful wherever he was, and always bettered himself with each move. Mary Walker, on the other hand, simply failed each time she attempted her hand at medicine. No biographer can attribute this failure to sex, for too many women physicians had been achieving professional stature, winning favor and friends. No, it was the old story of personality deficiency. People did not like Mary, and she marched on toward senescence, lonely and bitter.

She indulged in more and more bizarre announcements, lectures, letters, ideas, actions, and peculiar behavioral patterns. She became a clerk in the United States Treasury at Washington where confirmation of a permanent appointment failed because fellow-employees walked out on a woman who reported for work attired in pants. She clerked for a year in the Department of the Interior. At no time did she relent in her legislative petitions, either for reform or relief (and many of these activities, even Mrs. Poynter grudgingly concedes, were "fantastic"), or for claims for back pay, pensions, and sums owed her by the government. In her endless career as an unpaid lobbyist, no reporter was ever certain if Mary was championing a cause for herself or some highly imaginative and impossible program for the populace. She felt that a brief study of law endowed her with the right to be an expert on constitutional government. She pored over the federal constitution and came up with the quasi-argument to claim that our country's forefathers had always intended that women should be allowed the right to vote. So illogical and impractical were her arguments that her own sisters-in-arms, the National Suffrage Association, disavowed and thereafter ignored her. The strategy of winning favor for the female sex's demands was left to the calmer and rational minds of Susan B. Anthony and Elizabeth Cady Stanton.

Meanwhile, Mary Walker began to suffer with failing eyesight, and one of her many petitions finally struck meager pay dirt. She was granted a disability pension of $8.50 a month, which later was raised to $20! During the period immediately before and during the first World War, this pittance was an insufficient provision for a feeble, ailing, and lonely old woman.

Once or twice she had flashes of practicality which have proved to be beneficial to mankind and the everyday life of America. For example, the return receipt for registered mail matter is her brain child, as is the privilege of inscribing a return address on an envelope. But these were infrequent oases in the vast, endless and inevitable desert of mental turmoil which, despite intellectual acuity, gradually yielded to the ravages of deterioration. Unconscious desires finally surrendered to demands of reality. A sparse and dwindling practice had failed to bring her economic security. Eventually she was forced to admit to herself that a medical career was not for her. With this realization she had to humble herself; she was compelled to face more degrading embar-

rassment, more humiliation. Toward the close of the last century it was not unusual to find Mary on exhibition at cheap dime museums. At one time, she almost accepted a vaudeville engagement. If this were not enough of a cross to bear, there was the series of fractured legs she suffered in Washington in 1889 and 1890. From time to time she succeeded in having her tracts and books published, but she never made best-seller lists. Her wild ideas and her aloof literary style made such tomes as *Hit* and *Unmasked or the Science of Immortality* psychiatric curiosities or crank productions which the public would not buy.

Like every paranoid and paranoiac, she never could see eye-to-eye with the majority or general opinion. While she was nonconformist in matters of dress, in politics, in medicine, she would inveigh as she did in 1898, against the annexation of Hawaii, the war against Spain, and capital punishment. In 1918, she suggested that persons sentenced to death should be condemned to dig coal for life to prevent such fuel shortages as were common during the first World War.

Mrs. Poynter claims that Mary Walker faced cruel ridicule all her life with the stoicism of a martyr. The biographer also avers that "the press was largely responsible for the false reputation fastened upon her [Dr. Walker] which she never managed entirely to live down." More likely it was Dr. Walker's deviation from the norm that was "largely responsible" for the ridicule she earned for herself. Mrs. Poynter goes on to state that Mary Walker, despite criticism of her weird style of dress, seemed "dapper" in male attire, and "quite imposing in tails, with diamond studs, tall hat and Inverness." It is doubtful that public scorn would have been any less vehement whether the physician looked like Beau Brummel or a travesty on manly dress. Her penchant for opposing the conventional and accepted standards finally culminated in an abortive attempt to set up a sanatorium for tubercular patients in her home at Oswego. This project rapidly failed because of unfounded and fantastic medical ideas, insufficient funds, and public distrust.

Finally, Mary Walker became so incapacitated and ill that she required hospitalization. Ever the man, she entered the army's general hospital at Fort Ontario where she died at the age of 87 in 1919. How she must have reveled—in the next world—over the fact that her spirit left this globe on the birthday of one of

America's most virile, revolutionary and politico-military leaders —George Washington!

Psychiatrically, a review of Mary Walker's history clearly indicates a well-established diagnosis of paranoia, representing a compromise with reality unwelcomingly thrust upon a militant and determined ego that revolted against its sex, rebelling—not in a mere turn to homosexuality—but in an open, and as complete as possible, switch to the opposite sex. At best, Mary Walker was a poorly adjusted and chronically unhappy wretch of a woman.

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EDITORIAL COMMENT

AFTERCARE AFTERPAINS?

Some sort of aftercare must be as old as medicine. Imhotep doubtless prescribed regimens for his convalescing patients; the Hippocratic physicians certainly did; and special care for the invalid during recovery was well established in late medieval and early modern medical practice.

Leaning on a tree branch to keep weight off a wounded foot must have been virtually instinctive; and the necessities of splinting, bandaging and drainage must have brought aftercare principles very early in connection with surgery. The benefits of special diets after intestinal disturbances or severe fever must have been apparent as early. These measures were simply a matter of common sense after injury or illness—a need as apparent to the patient and his family as to the physician.

But planned aftercare for the mental patient is little more than half a century old. The ages of superstition surrounding mental disorder probably had a good deal to do with this. When mental disease was conceived of as possession by devils, the problem was religious, not medical; either prayers and exorcisms expelled the devils or did not. If the devils were not expelled, the victim was imprisoned or, during the few enlightened periods in the midst of many centuries of darkness, confined in an asylum. If the devils were expelled, their victim was obviously as well as anybody else and was released forthwith. Later, when derangment was considered the result of sin, which might be anything from blasphemy to masturbation or coveting a neighbor's wife, the sinner was locked up safely for the period of his divinely decreed punishment. When there was a remission, his punishment, by God at least, was over, and there was no reason to do anything but release him to live with his fellows—in the midst of opprobrium, of course.

For a century or more after medicine had re-established its right to treat mental disease like any other disease, this either/or attitude continued, as was natural. When a patient recovered, spontaneously or as a result of treatment in a medical asylum, he was released with no further concern. He was ambulatory, wasn't he? He had lost his symptoms, hadn't he? Then he was

well, wasn't he? A man was either insane and locked up, or he was sane and at large. The only trouble with this reasoning was that it didn't fit the facts. It was obvious for many decades that many patients well enough to leave their institutions were not well enough to adjust in their home communities. Late in the 1800's, the State Charities Aid Association of New York decided to do something about them. The association's Committee on the Insane employed a social worker to follow up patients discharged from Manhattan State Hospital, and conclusively demonstrated their need for further help.

Just over a half-century ago—in 1911—the State of New York officially established an aftercare program. Psychiatric social workers were made out of hastily trained or untrained teachers or nurses, or were recruited from public and private agencies, where they may have been investigating the worthiness of persons receiving charity, mediating family disputes or trying to rescue "wayward" girls. They had to learn new techniques, deal with new kinds of people, master new theories, solve new problems. The theories they had to master were those of the medical discipline of psychiatry, and the problems they had to solve were those of persons convalescing from psychiatric illness and the problems of their families. The first clinics wrestled with the problems of the feeble-minded.

A new discipline in the bounds of social science, that of psychiatric social work, arose. Those trained in it soon became the least dispensable members of the treatment team of psychiatrist, social worker and psychologist—indeed for a time there was a hybrid combining the latter two—which linked the hospital ward and the clinic to the patient's home. In the half-century since, requirements, training and organization in the psychiatric social service field have changed vastly, but psychiatric social service has remained, through the decades, the outstretched arm and the strong hand of psychiatry in the protection from ill of the convalescent who is not yet strong enough mentally and emotionally to protect himself. In the course of carrying this responsibility, the requirements for educational preparation and professional training have developed—from the days when the nurse, the schoolteacher, the charitably inclined college or "finishing school" graduate and the person with a desire to do "something practical" in the way of home missionary work were recruited and trained

on the job—to the point where psychiatric social work is one of the most rigorous of the social science disciplines.

It should be freely admitted that some of the early workers, who were largely trained, or who trained themselves, while learning their jobs, were successful. In 1920, Dr. Richard H. Hutchings appointed a nurse as social worker to organize (or reorganize) the social work department at Utica (N.Y.) State Hospital. She had had general social work experience after graduation from the Utica State Hospital School of Nursing, and had taken postgraduate nursing courses at the Johns Hopkins Hospital and teaching courses at Columbia. She had worked at the Henry Street Settlement House under the famous Lilian Wald, and she had had organizing experience; when she was appointed social worker at Utica, she was executive secretary of the Herkimer County (N.Y.) Tuberculosis Association. Forty years ago, many other nurses and many teachers had to learn psychiatric social work while they performed it, as physicians of 150 years ago learned their profession by apprenticeship.

All this is brought to mind by the fact that in 40 years we seem to have completed a cycle and reached a point where assistance from the nursing profession is needed in the psychiatric social work field again. An article in the present issue of this journal cites the proposed use of public health nurses on an experimental basis in Syracuse, N. Y.* The national need, which Syracuse reflects, is presented in the discussion of the psychiatric manpower situation in the final report (to Congress) of the Joint Commission on Mental Illness and Health.** THE PSYCHIATRIC QUARTERLY has recently taken very sharp issue indeed with some of the conclusions and recommendations of the Joint Commission,† but it has no quarrel with, and nothing but approval of, the commission's general findings in the manpower area, although it certainly disagrees with some of the worse than peculiar proposals concerning what to do about it. The report remarks, "Psychiatric social

*Cumming, J.; Bigelow, N.; Halpern, A. L.; Calthrop, C., and Crill, M.: The public health nurse and aftercare. PSYCHIAT. QUART. SUPPL., 35: Part 2, 203-211, 1961.

**Joint Commission on Mental Illness and Health: Action for Mental Health. Pp. 150-151. Basic Books. New York. 1961.

†Editorial: "No originality of proposition or proof." PSYCHIAT. QUART., 35:3, 576-585, July 1961.

Editorial: One-eyed jacks and deuces wild. PSYCHIAT. QUART., 35:4, 777-784, October 1961.

workers fall in the category with the highest training and are commonly regarded as an elite group in their profession." But it also notes, "Only a tiny fraction of the 80,000 social workers in the United States are psychiatric social workers," and it cites Albee's estimate in 1959 that 50,000 more social workers would be needed by 1960, an estimate in a study made for the Joint Commission.* Cumming, et al. remark, in their present paper, that it had been hoped for some time that the schools of social work would turn out enough new graduates to make up for the manpower deficiency, but that they now consider that, nation-wide, "this is a dubious hope."** In the Syracuse instance, Cumming and his associates called for help on the public health nurses of the county in which Syracuse is located—with results which may prove promising.

There are problems in any such experiment, however. The time is well over a generation past when one could call legitimately on untrained but supposedly charitable volunteers to undertake a job requiring professional education and training. There was once an ill-defined and nebulously-bounded field where all kinds of volunteers engaged in activities of real or ostensible private charity, home mission work and capriciously-directed philanthropy. In a Broadway show of the 1920's,† a tough young girl of that day's "lost generation" sang, to the tune of *My Bonnie Lies Over the Ocean,* a little verse reflecting on the activities and motivations of some of the time's amateur "do-gooders."

My father's a mis-si-o-nary;
He works to save ladies of sin;
He'll save you a blonde for a dollar.
Good god, how the money rolls in!

Those were days when almost any kind of untrained or half-trained workers—if organized and directed by professionals—represented an improvement. Today's professional social worker is a college graduate with two years or more of postgraduate special study and training in the professional skills and attitudes needed for dealing with a wide and constantly shifting variety of distressful personal and familial situations.

*Albee, George W.: Mental Health Manpower Trends. Basic Books. New York. 1959.

**Cumming, et al.: Op. cit.

†Howard, Sidney: Ned McCobb's Daughter.

Professional social work grew under the pressure of necessity; one must needs go—somehow—whom the devil of poverty or mental abnormality drives. The heart of today's social work is the development and use of the professional attitude and the professional relationship toward the person in need of help. It is an attitude that respects individual differences, understands the emotionally-based need to be accepted without reference to faults or failures, understands and responds sympathetically to outbursts of feelings, and respects the individual's right to make his own (even if wrong) decisions about his life, under the limitations of his situation and his personal limitations of understanding. The professional social worker has learned not to judge or condemn, and has learned how to listen to and how to keep a family's or a patient's disclosures—no matter how personally unacceptable—in safe confidence. This is a far distance along the road from the days when nonprofessionals met the unfortunate, the futile and the foolish with pleas, preaching, prayer, penance, or rousing, revivalist exhortations to repentance. It has taken the profession two score years and the individual worker his own many years of study and field training to reach today's level. And it would be unthinkable today to return the unfortunate person, half-recovered from a psychiatric illness to the ministrations of people, however well-intentioned, who begin their efforts with value judgments, if not moral judgments, and continue with conscious appeals to inadequately supported egos and poorly integrated super-egos. Fortunately there seems to be a workable alternative.

Before discussing this alternative, however, it may be well to review the education and experience for which one is seeking an alternative. Psychiatric social work, even if viewed superficially from the outside, is a difficult discipline to acquire and an even more difficult one to practise successfully. It demands first the four years of college work which are supposed, among a great many other desiderata, to teach the student about other ways of living than his own and so inculcate a disposition toward tolerance and understanding, if not some ability to empathize. Two years of class work after college involve intensive study of the social services, with their history, methods and present programs; human growth and change; casework methods; group work; and research. Social work deals primarily with the social and family situation of a person; the worker must learn to diagnose such situations

and their stresses, and formulate treatment programs to deal with them; while doctor and nurse are accustomed primarily to move from the individual to the group—if they, in fact, ever reach the group situation at all, which many doctors and nurses outside psychiatry never do.

The psychiatric social worker, of course, does not overlook the individual; he must know normal and deviant behavior, and must know what cultural, psychological and medical factors influence such behavior. He must, though he himself never undertakes to do medical treatment, know what it is, understand its theory, and be familiar with its results and with the principles of care and treatment in convalescence, if he is to judge whether his particular charges are progressing satisfactorily or are showing signs of relapse and renewed need of medical help. Today's psychiatric social worker must, like the psychiatrist himself, also learn to know himself, must also become aware of his motivations, attitudes and prejudices, and must also learn the self-discipline required to suppress personal biases and value-judgments of behavior.

In recent years, the burden of the psychiatric social worker has increased. As Cumming, et al. remark, the state hospitals are now discharging nearly all of the young and middle-aged patients they admit, chiefly as a result of treatment with the phrenopraxic —tranquilizing, anti-schizophrenic and mood-elevating—drugs. If it has not been possible to double a hospital's social service staff, it may have been necessary to double the caseloads of the individual workers. It has also been necessary to add, to the skills of the workers, abilities to detect side effects and to recognize signs of a convalescent patient's failure to continue on prescribed, proper dosage. The increasingly varied areas of knowledge and the increasingly numerous skills required are developed through carefully supervised experience, as well as formal study courses. In the field work of the training period, a student may carry four to 10 cases on which he will have expert help in analyzing the problems encountered.

It is easy to underestimate and difficult to exaggerate the extent of professional equipment needed by today's psychiatric caseworker. A worker must be prepared, for instance, to tell a patient who wants to work but doesn't know how to go about it where and how to look for a job; to advise a family in need of financial assistance where and how to apply. The worker must, in short,

know all a community's resources for help and must also know how to persuade a person in need to take advantage of them without fear or ambivalence.

The psychiatric social worker's education and training never end. There are staff conferences, discussions, and lectures which make up part of keeping up with professional advance. The worker plays a most active, and sometimes decisive, part in conferences where patients are considered for release. The worker, as has already been noted, must be well acquainted with what new drugs are administered, with their dosages, side effects, and usual and atypical reactions to them.

Nobody expects to find, outside the social work field, persons equipped with all the training and resources of the social worker —any more than one would expect to find competent internists or surgeons outside the ranks of the medically trained. But there is a glaring need, and the expedient tried in Syracuse may point toward a partial solution.

The training of most student nurses is, in sharp contrast with that of the student social workers, primarily oriented about general medicine and surgery. In place of four years of general college work, the student nurse has one, plus two years of further study and practice. With shorter vacations than the colleges allow, the nurse's education involves as much classroom and training time as does a college education; it is unnecessary to detail here the differences in scope and orientation. The social worker, even when not specializing in psychiatric social work, has much training in the general principles of psychology and the elements of psychodynamics. Except in the state hospital schools of nursing, concepts of psychiatry, dynamic psychology and psychosomatic medicine are not taught adequately. The usual 12-week affiliation is far from sufficient exposure to the principles and practice of nursing mental illness. It is just sufficient exposure to frighten many and insufficient acquaintanceship to attract many.

Few public health nurses have had good training in psychiatric nursing. The public health nurse does, however, have many assets which can be used in the field of psychiatric social service. She is well acquainted with community service organizations and available public agencies. She has had much training in public health principles, and has taken graduate courses in sociology, psychology, or human growth and development. And she may

have done graduate work in psychiatric nursing; such courses are becoming more common.

One cannot make a public health nurse into a psychiatric social worker simply by renaming her one—as Friar Tuck in the tale of Robin Hood rechristened a fast day venison pasty "salmon." This discussion envisages no such metamorphosis, in the present or future. What it does envisage is the taking over, during the present shortage of psychiatric social workers, of certain tasks that the public health nurse is well adapted, with some additional training, to undertake. Fortunately, with widespread preventive measures and the development of the antibiotics, communicable diseases, which used to require so much of the public health nurse's time, have been almost eliminated. With the aging of the population, the proportions of chronically ill persons and of those with emotional problems have increased; the public health nurse sees much more of this sort of thing than she did a few decades ago.

The Syracuse experiment, reported in this issue of THE SUPPLEMENT, was based on these changes in the public health nurse's situation and on other considerations which appeared to indicate that she could be helpful. An intensive, though admittedly very short, course in psychiatric nursing was given to the public health nursing supervisors at a state hospital, together with some indoctrination in the theory and practice of social work. It should be emphasized that the aim was to train them, not to replace social workers, but to act as psychiatrically-informed nurses on a medical team of psychiatrist, psychologist, psychiatric social worker and nurse. The nurse is very well adapted indeed for the performance of certain of today's tasks. She is as well-equipped as anybody could be to detect early signs of failure to take medication, or of overmedication or untoward side effects; she has been watching for such things all her nursing career; and she needs only to learn about certain new drugs, for problems with tranquilizers make up an increasingly large proportion of those with which today's psychiatric social worker must cope. The patient may not take them at all; he may hoard what is prescribed and then take a single massive overdose; or he may take his proper dose but suffer some highly unpleasant if not serious side effect. If the public health nurse can take over the purely medical problems in this area, the burden on the psychiatric social worker will be relieved greatly.

Of course if the nurse can handle the medication problem, she can learn to handle others. But it is not easy to learn or to understand psychiatry or psychiatric social work. The training and experience of many nurses, in fact, is antithetic to this particular learning process. The public health nurse who is alert to conscious pretense and malingering is conditioned to mistake psychiatric symptoms for them. Or she may mistake malignant, psychological, interpersonal stresses for culturally-conditioned family fighting.

Even in a limited field and with every care to teach painstakingly and enlarge responsibilities slowly, the nurse cannot be expected to replace the social worker. The social worker will have to do constant supervision, and be available for constant consultation. Teaching, handling the difficult cases personally, jumping into trouble spots, and taking on increased loads in the hospital itself, as proportions of discharges rise, will also be jobs that the social workers cannot delegate.

It must be remembered that the Syracuse effort is experimental and that judgments are tentative. Even if the worth of the effort is established as high, there will be complex administrative difficulties, educational problems and co-ordination difficulties. Most psychiatric social workers (in New York State at least) are state employees; public health nurses may be employed by city, county or private organization. Until questions of supervision and responsibility without authority are solved, the social worker's role will be no easy one.

The facts remain, however, that the public health nurses can help do a job that is taxing the social workers sorely, that those nurses are now dealing with many of the same families and individuals as the social workers, and that to fail to use them as social work aides would be most wasteful of professional personnel. It would seem logical to assign the individual patient to social worker and nurse according to the patient's needs, and with particular reference to the types, levels and orientations of the professional skills needed. If this is to be accomplished, however, it will require the joint efforts of the two professions to devise, without sibling rivalry, effective training programs and workable administrative plans. It is likely that more local experiments along the lines of the one in Syracuse would develop methods and means of general application. With the welfare at stake of thousands of persons who are still ill and still in need, strong

efforts by administrators responsible for aftercare, and strong united efforts in both nursing and psychiatric social work groups are imperative.

THE EDITOR

BOOK REVIEWS

Anatomy of the Future. By RODERICK SEIDENBERG. 173 pages. Cloth. University of North Carolina Press. Chapel Hill. 1961. Price $3.50.

Seidenberg, a philosopher of history, presents an exploration of the future's possibilities particularly insofar as the principles which have been somewhat more jocularly considered by Northcote Parkinson are operative. Seidenberg, like Parkinson, tells us that organization breeds more of the same *ad nauseam*. There was another fellow who had the same notion. His thoughts have come down to us under the name of *Ecclesiasticus*. Parkinson never considered the possibility that intelligence might offer a way out of the rat-race he described (and in which most of us live), but this is a major consideration of Seidenberg and occupies his pages 78-131. He comes to the conclusion that organization is a product of intelligence, that the breeding of more organization by organization must ultimately come to a halt, and that a biologically stable state will ensue. Like the Preacher, Seidenberg sees man's role as one of balancing reason against instinct.

This brings Seidenberg face to face with the problem of the necessity of mental health. He (rightly) sees no possibility of evolving a higher form of intellect except, perhaps, by breeding, and he also recognizes the dependence of the people upon society for the best realization of mental health. Where *Ecclesiasticus* saw social order in the love of God, and Freud envisioned it in the triumph of eternal Eros, Seidenberg comes to the conclusion that there is a set drive toward collectivism in the social life of man.

The individual of the future, according to Seidenberg, is as surely doomed to anonymity as the snowflake which becomes lost in the drift it joins. He concludes, "With statistical finesse, man promises to come into his own on a basis that will cancel in one vast assimilation the light of his long striving, and in the ballet of the future he may find release from his travail in an endless routine of unchanging responses."

It is easy enough to disagree with Seidenberg's conclusions but one should familiarize one's self with his argument before doing so. Most persons will probably find the author better informed about the things that matter in their fields than they are about his. Seidenberg has read widely and well. The reviewer's own criticism of Seidenberg's thesis is that he anticipates the logical end of the process on which he builds that thesis at a point earlier in the future than the reviewer thinks is foreseeable. In the meanwhile the reviewer is inclined to believe that Amaury de Riencourt's anticipation of an illogical future on the basis of an illogical past, as expressed in *The Coming Caesars,* is much closer to what we can expect for a long, long while than is Seidenberg's anticipation of a logical one.

Heredity and Your Life. Second edition. By A. M. WINCHESTER. xii and 333 pages. Paper. Dover. New York. 1960. Price $1.45.

This is a straightforward, elementary text in the field of genetics. There will be some cavilling on the part of psychodynamicists about the emphasis given by the author to the role of genetics in disorders such as schizophrenia, but the evidence is in Winchester's favor if one remembers that his concern is not with the expression of an explanation of *all* phenotypes. (For one alternative, equally unpalatable to the psychodynamicist, see the book by Ashley Montagu, *Prenatal Influences,* reviewed elsewhere in this issue.)

If one wants a good, unpretentious, introductory text on genetics, at a reasonable price, this is recommended. Note, however, that plate XVII has been turned on its side and does not, therefore, agree with the legend.

Alcohol. Its History, Folklore and Its Effect on the Human Body. By BERTON ROUECHÉ. 151 pages. Paper. Grove. (A Black Cat Book) New York. 1962. Price 50 cents.

This is the same book which was unenthusiastically reviewed in THE PSYCHIATRIC QUARTERLY SUPPLEMENT, 34:169, Part 1, 1960 under the title of *The Neutral Spirit.*

Prenatal Influences. By M. F. ASHLEY MONTAGU. 614 pages. Cloth. Thomas. Springfield, Ill. 1962. Price $17.75.

The essence of Montagu's argument is summed up in a quotation he reproduces (p. 499) from Warkany:

"It is not yet clear whose task it is to investigate, prevent, and treat prenatal diseases. So long as it was thought that a mother who appears healthy guarantees complete protection of the child in utero, obstetrical care was considered adequate for the fetus. But since there is increasing evidence that the unborn child can be injured by agents well tolerated by the mother, this old belief cannot be upheld. Today the field of prenatal pathology is a no man's land between obstetrics and pediatrics in which progress has not been adequate."

This is a fast-moving and important field. Many pathologists, like Philip Schwartz, feel that the future will see the development of extensive antenatal controls. If there is any area at which the problem of mental retardation is immediately accessible, it is here. Montagu knows the material of his subject thoroughly, and while not everyone will agree with his degree of emphasis upon environmental influences, as contrasted with genetic, much of this disagreement can be resolved at the level of definition. The book is important. Its author deserves a wider audience than the price (which this reviewer considers a thoroughly exorbitant one) the publisher has placed upon the book is going to encourage.

The Prognosis After Sterilization on Social-Psychiatric Grounds. A Follow-up Study of 225 Women. By MARTIN EKBLAD. 162 pages. Paper. Ejnar Munksgaard. Copenhagen. 1961. Price: Free to subscribers to *Acta Psychiatrica Scandinavica.*

This is an enlightening study of timely interest. Although sterilization was legal in certain categories in Sweden prior to the Swedish Sterilization Act of July 1, 1941, this act gives explicit indications. Sterilization is understood in the limited sense, i.e., not castration.

Sterilization is legal in Sweden on eugenic, social and medical grounds. The medical indications reported in this study were often of psychiatric nature. In 85 per cent of the cases reported, sterilization and abortion were simultaneously performed. Most women reported that they were satisfied with the sterilization procedures. Some others reported some change in libido; some felt guilty; some had physical complaints, more or less of a psychosomatic nature. Three women requested and had plastic operations to reverse sterilization; one of the women became pregnant later on.

The Swedish Board of Health reported in 1957 that 1,785 sterilizations were carried out, of which 97 per cent were performed on women. This volume of *Acta Psychiatrica Scandinavica* (Supplementum 161) has a comprehensive summation. It is this reviewer's opinion that we in the United States can learn from study of the Swedish sterilization procedures.

Conditioned Reflexes. By IVAN PAVLOV. 430 pages. Paper. Dover. New York. 1961. Price $2.25.

This is an English translation under the auspices of the University of Cambridge of Pavlov's original lectures on the conditioned reflex and is a full description of his work up until 1924. The principles of the conditioned reflex have been extended since then, and the Russian school of psychiatry has based much of its principles of treatment on this basis.

As a historical document, this book is important and should be in every psychiatric library. To most readers it will prove rather boring because of the great amount of detail and the seeming repetitiousness of the material. It will, however, always be useful as a reference book.

Man Against Aging. By ROBERT S. DE ROPP. 310 pages. Paper. Grove. (A Black Cat Book) New York. 1962. Price 75 cents.

This paperback reprint of a 1960 publication is, of course, intended for the layman. It is well-written, contains no obvious, serious *faux pas,* and the choice of material is apropos. The fads of the past are reviewed (what an odd feeling is created by having names like Steinach and Voronoff—now so totally silent—recalled!) and the present is examined in appropriate perspective.

Ishi in Two Worlds. By THEODORA KROEBER. 255 pages. Cloth. University of California Press. Berkeley. 1961. Price $5.95.

The biography of Ishi is a fantastic but true story of the survival into the twentieth century of a California Indian whose extinct tribe was in the Stone Age in technology and apparently in social organization. Ishi, captured as a "wild man," was taken to San Francisco where he came under the protection of two distinguished anthropologists, T. T. Waterman and Louis Kroeber. This account of his life is by Professor Kroeber's widow. A condensed version of it has appeared in *The Readers Digest.*

Ishi's quick and willing adaptation to modern civilization is a story of great value to the student of acculturation. Ishi's medical history, and what can be gained from his story of his psychology and that of his Yahi tribe, are also of more than a little worth to the social scientist.

Problems in Communication. CHARLES WATKINS and BENJAMIN PASAMANICK, editors. 131 pages. Paper. American Psychiatric Association. Washington, D. C. 1961. Price $2.00.

There are some excellent books available on the subject of communication. This is not only not among that group, but several of its contributors seem to be generally unaware of what water has gone over that particular dam. The structuring of the conference which gave rise to this monograph is of such a nature that the first principles of communication are violated by both organization and choice of participants. To begin with, the reader is bound to have a hard time deciding what the conference has to do with communication. It is not until one gets to page 62 that he becomes aware that Watkins has basic communications problems from the start. H. E. King (a perceptive psychologist from Pittsburgh) explains that Watkins overcame King's own puzzlement by stating "that although the formal word for the theme of the meetings was to be communication, a broader statement of its concern might be, 'How do we come to know what we do about the psychiatric patient?' "

Confusion of purpose is not the only difficulty with the monograph. Some of its contributors have both logical and expositive difficulties. One would least expect these from a professor of English, but consider Connor's (associate professor of English, Rice University) contributions to confusion. Connor says, on page 52, "For the other two sorts of problems we are indebted to B. L. Whorf..." and then goes on to state that "Whorf noticed (what every acute student had noticed before)..." This is the sort of writing that should have been sent back to the author in the composition stage. On a footnote to this form of indebtedness to one person for knowledge allegedly in the common domain, Connor gives us a beautiful example of how to sabotage communication. He says: "*Phenotype* and *cryptotype,* as used here, are not Whorf's phenotype and

cryptotype. When Whorf uses those words, he means by them something different from what I mean by them in this paper. Anyone who wants to know what it is can read Whorf, who explains it very well. If I use the words as Whorf used them, I will not be able to make the points I want to make. It is a shame that Whorf appropriated these awe-inspiring words to a relatively stodgy distinction. Let the blunder stand corrected for the time being."

Like charity, problems in communication would appear to begin at home.

The Murderers. By HARRY J. ANSLINGER. 308 pages. Cloth. Farrar, Straus and Cudahy. New York. 1962. Price $4.95.

Mr. Anslinger, the first and only commissioner of narcotics in the United States, has compiled a book on the legal administration of the Harrison Act. It is poorly written and suffers from frequent repetition. However, the author does make his point that the narcotics trade is an evil controlled by gangsters, that it brings large sums of money to sellers and that it results in moral and physical deterioration of its victims, and frequently in death.

Although the author states that the only treatment for the addict is medical and psychiatric, he is not concerned primarily with treatment, but with the prevention of sale, especially before the drug reaches the final pusher. His attitude is that of the punitive law enforcement officer. He stresses the importance of severe laws against the sale of narcotics. As in his public statements, Mr. Anslinger tends to exaggerate, apparently from sincerity, in order to stress the importance of this problem. In one of the chapters toward the end of the book, he attempts to justify his treatment of, and answers the statements made by, Alexander King.

There is nothing new or startling in the book although one might well expect such material from the commissioner of the Federal Bureau of Narcotics. However, there is considerable information in it concerning the operation of the narcotics merchants, which should be known by those interested in, or dealing with, the problem of narcotics.

Molders of the Modern Mind. By ROBERT B. DOWNS. 396 pages, including index. Paper. Barnes & Noble. New York. 1961. Price $2.25.

Downs here reviews "111 books that shaped Western civilization." The authors range from Cervantes to Havelock Ellis and Freud, and all the way to Horatio Alger, Jr. There is a handy table of names, dates and brief bibliographical data. The reviewer thinks this is useful as a reading guide and for reference. A tremendous amount of research and writing is involved in it.

Psychology of Judgment and Choice. By FRANK RESTLE. xiii and 235 pages, including index. Cloth. Wiley. New York. 1961. Price $6.95.

Mathematical models of behavior currently enjoy considerable prestige in the scientific community. It is not clear that they have earned it as yet, although they surely will in time. This book develops one type of mathematical-set theoretic analysis of some types of behavior in which subjects are asked to make choices or judgments. It possesses little of the generality implied in the title.

The mathematics is not easy going, but should not be overwhelming to those with some facility with algebra and abstract thinking. An excellent introduction to set and probability theory is provided in the first quarter of the book. This alone is worth the attention of anyone concerned with mathematics in modern psychology. The case for mathematical theory in psychology is presented masterfully and concisely. The case against it is skirted. The weaknesses of the present theory are acknowledged modestly. The author confesses that "the real reason for writing the book is not to arrive at final conclusions but to help stimulate deeper and more complete analysis of the experimental topics treated." He achieves his aim.

For the most part, the theoretical model is related to representative data culled from the literature of the past decade. Very few new data from experiments generated by the theory are available. Among the topics treated are simple choice, prediction of alternatives (guessing patterns), simple reaction time, reversible figures, target detection, and judgment (estimation) in psychophysical experiments. Something useful can be learned from this discussion about current thinking in such areas, even if the mathematical analysis is bypassed. However, it is disappointing that many regions of contact of the present theory with other current behavior theories are not discussed.

The author, Dr. Restle, is associate professor of psychology at Michigan State University.

The Physician's Guide to the MMPI. By PATRICIA KING-ELLISON GOOD and JOHN P. BRANTNER. 69 pages. Paper. University of Minnesota Press. Minneapolis. 1961. Price $1.85.

This monograph is an attempt to explain to the practising physician the Minnesota Multiphasic Personality Inventory. It gives a short description of the type of questions, their number and classification, and the various groups, the mode of scoring, both raw and weighted, and the interpretation of certain common types. Its use and interpretation are described, and frequent referral is made to the atlas and manual. As a short discussion for somebody who knows something about the MMPI, it is excellent. For one who knows nothing about the test, it would be completely baffling.

The Tempter. By ANTHONY BLOOMFIELD. 255 pages. Cloth. Scribner's. New York. 1961. Price $3.95.

Bloomfield's novel is a sort of dream-allegory, in which Sammy, seller of pornographic books and secret producer of sex movies in a never-never London, plays a role compounded of Satan and Christ, while others engage in every sort of sex activity before the camera, and then take up private lives of child-like innocence. These people are (presumably intentionally) caricatures of textbook schizophrenics, and their performance has the quality, not of life, but of a pantomime pageant. With these limits laid down, *The Tempter* is something of a *tour de force* that is worth the attention of almost any student of the human mind and its fantasies.

Since You Ask Me. By ANN LANDERS. xv and 206 pages. Cloth. Prentice-Hall. Englewood Cliffs, N. J. 1961. Price $3.50.

Ann Landers is one of the two best-known contemporary newspaper advice-colmunists; the other is her twin sister, whose pen name is Abigail Van Buren, and who published collections from her column in book form some time ago. Ann Landers' is a well-rounded, basically sound book, written with a sense of humor; and the emphasis is on interpersonal problems, with mates in marriage, with in-laws, with parents, children, siblings, which is where emphasis in general counseling belongs. In general, her book is good mental hygiene. The author advises psychiatric help where she recognizes the need. She sometimes fails to recognize it; but it is fair to say that the professionals themselves sometimes fail also.

The Primal Urge. By BRIAN ALDISS. 191 pages. Paper. Ballantine. New York. 1961. Price 50 cents.

This is a "science fiction" story compounded of nonsensical neurology, superficial psychology and silly psychiatry. Title, garish cover illustration and the cast of principal characters may all suggest the erotic; but, aside from a single scene, the book will disappoint the pornography-seeker. There are a few shafts of serious satire, but the book in general is rather a literate lampoon of sophisticated modern society. Take it as fantasy, and it is amusing, and occasionally thought-provoking.

The Art of Thinking. By DAGOBERT D. RUNES. 90 pages. Cloth. Philosophical Library, Inc. New York. 1961. Price $2.75.

This little book has no resemblance at all to the work of the same name written by Dimnet a few decades back. It is not a systematic treatise on mental processes but rather a collection of random thoughts on a variety of subjects such as the law and segregation.

Must You Conform? By ROBERT LINDNER. 210 pages. Grove. (A Black Cat Book) New York. 1961. Price 60 cents.

As the title of this reprint of Lindner's 1956 collection of essays suggests, he took his psychoanalytic hatchet into the forest of things-as-they-are. The lines are well drawn among Lindner's readers—he was either a dog or a new Mencken. Any of the essays in this little book are well worth the price of admission and Lindner deserves a better audience than Black Cat angles for, with a full-color pastry cover suggestive of prostitution.

The most doggish aspect of Lindner's approach is not his tendency to snap but a certain exuberance which makes him, like an immature hunter, overrun the scent. Neither was he any Mencken. Mencken's attacks were ponderous affairs carefully maneuvered into place with a view toward crushing the wowsers. In his generally *gemütlich* deliberations, Mencken never betrayed his educated palate, and if he was enough of a practical newspaperman to know that he was often going to have to put up with beer and Phillies, instead of burgundy and Corona coronas, he has sense enough to ask for good beer and never to confuse tourist trips to paradise, via the woman route, with beauty. This is saying that Lindner was on the right track, but he had a long way to go and missed some of the nicest scenery because he was traveling too fast to see it.

The goal he evidently headed for is the delimitation of the traits which raise an individual above mediocrity and still do not qualify him as a screwball. Lindner had tripped over the shifting barriers which society moves about in this territory, placing them now here and now there, depending upon whether it wishes to encourage or damn a particular individual. He tried, therefore, to establish a set of criteria that couldn't be jockeyed about. His effort to do this on the basis of psychoanalysis was not very convincing. The subject is a succulent one and invites protracted consideration, but there is one aspect of the problem Lindner did not mention. It is that really creative individuals often don't give a damn what happens to them because they enjoy themselves so thoroughly. Don Marquis dwelt on this in his little poem about the moth, in *Archy and Mehitabel*. There is another type of nonconformist (Sir Harry Lauder's "man who is a man") who also doesn't care what happens to him—not because, like the creative genius, he hasn't thought about it, but because he has considered the consequences of integrity and moves forward with cynical certainty to the cup of hemlock, the cross or, more commonly and less spectacularly, to the bills incurred by the Samaritan and the social rewards of leprosy. Of course, a psychoanalytic explanation can easily be brought forward also for such situations, but psychoanalytic theory is also a manipulable code and one that breeds its own swarm of gray flannel brains. The truly wonderful thing about individuality is just that—its unique

character. It makes its own congruences and values. When it also accepts its own responsibilities for these, it becomes superb and transcends all the rules. Lindner was mistaken when he implied that individuality was at low ebb in the medieval period or that it is less real today than one or two generations back. He was, however, doing a good job in laying about him with his axe among the dead wood of Billiken's forest. It would have been interesting to see how he would have developed if he had lived long enough.

Hitler's Heirs. By PAUL MESKIL. 191 pages. Paper. Pyramid. New York. 1961. Price 50 cents.

This is a paperback written in reportorial style.

Each chapter deals with one, or a group, of Hitler's henchmen, describing something of their background and going into great detail concerning their parts in various atrocities. After a short time, the presentation becomes both overwhelming and depressing.

The author's main theme is that many of the leaders in the Hitler movement are still in important positions in both East and West Germany, that many who were supposed to be dead, and others who are known to be alive, are strategically placed in various other parts of the world —and that all are combined in a vast international fascist network called "The Spider." Many of the rightist organizations in countries outside Germany, including the United States, appear, says the author, to have some relationship to this international organization.

Mental Patients in Transition. MILTON GREENBLATT, M.D., DANIEL J. LEVINSON, Ph.D., and GERALD KLERMAN, M.D., editors. 378 pages. Cloth. Thomas. Springfield, Ill. 1961. Price $11.75.

This volume is the result of the editors' work in planning, directing, and reproducing proceedings held in Boston in March, 1960 to discuss the transition of patients from hospital to community.

It is divided into several sections. Part I deals with discharge plans in the hospital, and considers the reactions to discharge of patients in various facilities: a psychosomatic unit, a psychiatric unit of a general hospital, a private psychiatric hospital, and a state hospital. Part II deals with certain special facilities which have developed in recent years such as the day hospital, the halfway house, ex-patients' clubs and the hospital as a center for community activities. Part III deals with special facilities within the community in maintaining ex-patients and in preventing reinstitutionalization. Part IV deals with family influences on patients' adjustments after hospitalization, and Part V deals with the role of pharmacological agents following hospital discharge. Most of the articles are well-written and give a broad interpretation of newer concepts in the care of ex-patients.

This is a book which should be in every psychiatric library.

Anthropology and Africa Today. ETHEL BOISSEVAIN, editor. 15 authors. 186 pages. Paper. New York Academy of Sciences. New York. 1962. Price $5.00.

In a monograph with the present title, one would expect to find considerable attention devoted to the rapidly shifting physical anthropological background of the emerging geopolitical African groups. There is, however, only one paper on physical anthropology, and that is a brief, rather academic, affair chiefly concerned with Leakey's Chellean man. Most of the monograph deals, not only with what is generally called cultural anthropology, but with the rather peripheral sociological and historical fringes of that. Such territory is sketchy and tentative at best; but, as Kopytoff implies in his paper, the day is past when the cultural anthropologist can expect his speculations to go unchallenged.

Africa is especially dangerous territory for cultural anthropologists from the United States. No one investing money in Africa today would select a United States firm to handle the intimate details of the venture. One chooses a British, French, Belgian or Swiss firm. As the saying goes in Africa, persons from the United States have "only recently entered Africa." As in the case of many commercial ventures the Boissevain monograph tends to remain at a distance from its subject. This is probably a safe course but not one which is particularly informative, and it certainly does not afford one any new insights. The New York Academy of Sciences has missed the opportunity to put out a really important monograph in an important area. One wishes that comparable time and effort had been expended in a systematic correlation of what our European colleagues have already found out but are unable to agree upon.

The L-Shaped Room. By LYNNE REID BANKS. 320 pages. Cloth. Simon and Schuster. New York. 1961. Price $4.50.

This is a novel about a girl in her late 20's who begins to wonder whether life is passing her by and seeks out a former boyfriend. She has an unsatisfactory night with him, deciding to return to her previous ways, but finds that she is pregnant.

The novel then deals with her resulting actions, with her father's typical Victorian reaction and her defiance by moving to a rundown rooming house area. Her vacillation concerning abortion: "To do or not to do," and her behavior with her new associates are described. There is no attempt at psychological understanding of her behavior and, to this reviewer at least, there was a feeling of forced action. Psychologically, this book has nothing to offer except frustration of the reader by the inability of the author to develop the numerous characters.

Dictionary of Aphrodisiacs. By HARRY E. WEDECK. 256 pages. Cloth. Philosophical Library. New York. 1961. Price $10.00.

Although this book claims to include "scientific" material, there is no mention of any materia medica more recent than cantharides. The entries are devoid of professional insight. Since the author is said to be lecturer in classics, Brooklyn College, N. Y., one is reminded that it was Plutarch who observed that "it is no disgrace not to be able to do everything; but to undertake, or pretend to do, what you are not made for, is not only shameful, but extremely troublesome and vexatious."

Projective Techniques With Children. A. I. RABIN and M. R. HAWORTH, editors. 392 pages. Cloth. Grune & Stratton. New York. 1960. Price $11.75.

This 21-chapter rapid survey of projective personality techniques was written by 22 authors. It lists and describes all projective techniques used in the study of children's personalities or their interhuman relationships. Written for students as an aid in teaching, the book does not contain all the information necessary to administer and interpret tests, but it can serve as a textbook to be supplemented by class instruction, much additional reading, and, of course, training in the actual use of the tests.

The editors and most contributors to this volume try hard to provide a psychoanalytic theory for their procedures, but it is a very highly edited form of psychoanalysis which might be acceptable even to Queen Victoria. Projection is defined simply as "externalization." Moreover, the link between the theory and the results of the tests presented in this book is so weak that one does not miss anything by skipping the theory. The reason is emphasis on ego-psychology with no meaningful reference to the unconscious. Freudian ego-psychology does not differ from the pre-Freudian psychology of conscious personality except that in it, the ego has to get along with the id and the super-ego. The complex interrelationship among these three Freudian "institutions" of personality cannot be reliably inferred from projective test data, and this difficult problem is not discussed, let alone solved, in this series of presentations.

The historically first projective technique, the word association test, is included, but its author's name, C. G. Jung, is absent from this book, which aims at completeness and is replete with names.

The volume contains some misinformation. For example, it is not true that the Rorschach test requires the subject to respond with the first image or idea and to do so as soon as possible. It is not true that Rorschach used "a vague psychoanalytic background" for his test. Not only is there no trace of psychoanalysis in the *Psychodiagnostics,* but Rorschach plainly stated that "the test cannot be used to probe into the content of the subconscious." He added that the test "can be of some service to the psychoanalyst" as a diagnostic aid and thus "can clear up those un-

pleasant situations arising when one has an analytic patient in whom there is a suspicion of schizophrenia." The theory offered in the present book is vague, sketchy and confusing rather than helpful. The best aspects of this volume are in its factual review of projective personality tests and its illustration of some of the applications of these tests to the understanding of children's personalities.

The Rising Gorge. By S. J. PERELMAN. 287 pages. Cloth. Simon and Schuster. New York. 1961. Price $4.50.

Perelman's humor is a hybrid of zany uninhibited flight and classical satire—"perelmanire." An old associate of the Marx brothers, Perelman differs from them in no respect more than in his underlying irritability. The book (like his previous *The Road to Miltown*) is not misnamed. In the pursuits in which Perelman earns his living (as a magazine contributor and Hollywood writer) it is difficult if not impossible to avoid typing, and it has been Perelman's fate to be typed as a humorist. There is, however, nothing basically humorous about having one's country home ransacked by housebreakers ("Open Letter to a Cold-Slough Mob"). Perelman's technique in producing a salable account of this event shows considerable reliance upon a souped-up imagination and sweating at a hard job of writing.

Perelman's good ear for the cloak-and-suit *motif*, whenever it turns up, and his ability to express this *motif* in recondite or outré words form the basis of his hard writing. He has certain other stock-in-trade tricks among which are three common ones which might be called the Weber-and-Fields vignette (*"Eine Kleine Mothmusik"*), the vaudeville stage caricature (various items about Englishmen, grand dames, British explorers), and the elaborated inference ("Dry Run—Everybody Down!" and other items based upon excerpts from the daily press or magazine articles). Much of Perelman's effectiveness is based upon familiarity with a wide range of facts and places. When he talks about Hollywood or Greenwich Village one knows he has put in his time. If it is London or Paris about which he talks, one recognizes that he has at least a tourist's acquaintance with these cities. He knows Bucks County as well as the Bronx.

Perelman's dilemma is everyman's. Shall he ignore the inanities forced upon us all, the obviously phony frauds, the unnecessary obstacles and red adhesive tape or should he cry out? There is nothing new about mindlessness or corruption as all the Latin satirists are ready to remind us. And there is less to be achieved by idealism than by a realistic, unmoral approach—as writers from Machiavelli to Emil Ludwig have demonstrated. What escape is there then from conformity or the nirvana of the tranquipill? Satire is a possible answer, but the objects of Perelman's ire are really dead horses, and their flogging is as easy as it can be tiresome. Perelman's imagination is active, but the world's facts are worse than his fictions imply.

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Conceptions of Perceptual Defence. By WILLIAM P. BROWN. viii and 106 pages. Paper. Cambridge University Press. New York. 1962. Price $4.50.

This monograph deals with the determination and measurement of an individual's response to a test situation which is, to a variable degree, emotionally and intellectually charged. Bruner and Postman used the term "perceptual defense" to explain their observation that "(a) The finding that words of an emotionally disturbing character were more difficult to recognize than neutral words were (Bruner & Postman, 1947). (b) The finding that words characteristic of a low value area were more difficult to recognize than words characteristic of a high value area were (Postman, Bruner & McGinnies, 1948.)"

Brown observes that Bruner and Postman's terms involved two different concepts. "(a) Any difference in ease of recognition between neutral and emotional stimuli. (b) That particular difference in ease of recognition between neutral and emotional stimuli in which emotional stimuli are more difficult to recognize than neutral stimuli are."

In the present monograph, he has directed his attention, as stated, to the "effect of stimulus emotionality upon recognition thresholds."

There was, of course, a good deal of work along this line, even before the publication of Bruner and Postman, and it is obvious that such work has a direct application within the framework of psychoanalytic theory. Brown does not arrive at any final explanation of perceptual defense. Rather he ends with two questions. "First, is it not necessary to treat perceptual defence as an epiphenomenon of repression, produced by generalization from thought to percept? And does not Dollard & Miller's (1950) analysis of repression necessarily form the basis of any competent theory of perceptual defence? Secondly, is it not equally essential to recognize that, when an emotional stimulus is being exposed, the tachistoscopic situation is endowed with an element of conflict?"

The methodology involved in this study is simple and lends itself to a variety of applications within the framework of psychiatric research. Indeed allied techniques have been employed for measurement of the presence and extent of affect and for the determination of the forces which trigger it. The monograph will also be useful to the reflective psychiatrist who wishes to learn more about the general field of behavior theory.

Ourselves to Know. By JOHN O'HARA. 408 pages. Cloth. Random House. New York. 1960. Price $4.95.

O'Hara has a sure hand at detailing characters and their relationships with their environment. Unfortunately, in this study of a man who murders his very young wife, his novel becomes long, is gimmicked and is not penetrating enough to make his study more than superficial.

Battle for the Mind. A Physiology of Conversion and Brain-Washing. By WILLIAM SARGANT. xxvii and 255 pages, including bibliography, illustrations and index. Paper. Penguin. Baltimore. 1961. Price $1.45.

This is a specially revised paperback edition of an extremely important book by one of Great Britain's most eminent psychiatrists. It was first published in this country by Doubleday in 1957. Sargant deals in it with the mechanics and the techniques of influencing or coercing the human mind from ancient times to the modern practices of Communist China. He finds the means to be essentially the overwhelming of the emotions—whether in the rise of some Hitler to power or in the revivalist's tent or in the constant physiological and psychological pressures of imprisonment behind the iron or bamboo curtain. He thinks that those fanatically indoctrinated already in some other belief, and, failing this, those of strong bodies and phlegmatic dispositions have the best chance of resistance. Of those with whom their jailers have no success, he remarks, "the stake, the gallows, the firing squad, the prison, or the madhouse, are usually available for the failures."

Sargant's explanations are strictly Pavlovian; he attributes Communist brain-washing success to Communist application of Pavlovian principles and suggests that the free world should devote more study to Pavlov and his work. The reviewer can concur with this and at the same time note that this should not exclude the possibility of either other or additional mechanisms.

Determinants of Infant Behavior. B. M. Foss, editor. 308 pages. Cloth. Wiley. New York. 1961. Price $6.75.

The result of the invitation of a number of outside speakers to a symposium of the Tavistock Study Group on Mother-Infant Interaction (of the Tavistock Child Development Research Unit), this is not a well integrated or systematic presentation of the subject. Some of the material, like that by Harry Harlow, has been widely available before; some, like the careful circumstantial contribution by Schneirla and his associates, would be more at home in one of the professional psychological journals. The contribution of the Tavistock Group itself does not form any significant part of either the text or discussion. The level of sophistication displayed in both the papers and discussion is very uneven. The bills for the Tavistock Unit appear to be paid, in part, by the Joseph Macy Jr. Foundation and the Ford Foundation. A somewhat propulsive enthusiasm is detectable but not entirely justifiable. This is projected in the promisory attitude of the publisher as stated on the jacket where a contribution from Prechtl is characterized as "extended." Prechtl's formal presentation, which seems to have been carried forward from running comments made during a motion picture, comes to slightly over a page and half (including its title and the author's name).

The Birth of an Institute. IVES HENDRICK, M.D., editor. xiv and 164 pages. Cloth. Bond Wheelwright. Freeport, Maine. 1961. Price $5.00.

The three essays (by Hendrick, Lewin and Menninger) which comprise the bulk of this volume were originally presented at the twenty-fifth anniversary of the Boston Psychoanalytic Institute in 1958. In the minds of most readers of this journal, the year of 1933 is still so recent that it is difficult to bring the pre-World War I reminiscences of the essayists into relation with the current state of psychoanalysis. The essays are commodious, genteel, scholarly, and, for those of us who remember Boston and worked in Boston before World War II, nostalgic. Anniversaries generally are times at which one or more of three purposes become apparent —that of looking backward with a view toward determining what has been accomplished, that of determining where an organization stands currently, and that of charting the course of the organization in the future. These three purposes become apparent here. Perhaps it is natural that most of the emphasis, in situations such as this one, should be on the past, but it is toward the future that an organization which has barely reached its chronologic majority must look.

The economics of group insurance, group practice, union and company physicians—in short, of the medicine of the future—cannot be reconciled to present psychoanalytic methodology. Neither can the needs of the individual be taken care of by adapting psychotherapy to the pressures of the group. Menninger sounds an ominous note (pp. 147-148) in pointing out that the character of psychoanalysis is such as to kill off its own propagation. There is another great difficulty which the future poses. It is the impossibility of fulfilling the promise of attending to the individual as a whole. This phrase has come to carry the tacit implication "by including my interest in," but we all know that everybody's interest can no longer be included "in." Some degree of disengagement is required, and, as any psychoanalyst knows, disengagment is not only a necessary accompaniment of aging but its avoidance exacts a terrible and final penalty.

Twilight of Honor. By AL DEWLEN. 328 pages. Cloth. McGraw-Hill. New York. 1961. Price $4.95.

Dewlin's latest novel is a Book-of-the-Month-Club selection and winner of the 1961 McGraw-Hill fiction award. The story concerns the motel-murder of a worthy citizen by an unsavory young drifter. It is a well-plotted novel, dealing with the trial, and recalling *Anatomy of a Murder*. The court is filled with colorful characters, and the tale of these people's lives, touched by the trial, both in the court and beyond, is dramatically told. The writer's characters seem psychologically sound, and altogether this is one of the most absorbing books of the type this reviewer has come across.

Criminal Psychology. RICHARD W. NICE, editor. 284 pages. Cloth. Philosophical Library. New York. 1962. Price $6.00.

Like all symposia, this book suffers from varied levels of writing. Some of the statements are far too general, and others are so specific that they have no general usefulness. In the introduction the editor quotes Bergler's views comparing criminal behavior with the oral neurotic, and then goes on to state that the criminal commits a specific crime for two reasons, an unconscious conflict and an attempt to solve this conflict. He continues, "The focal point of the criminal act is the repetition of injustices, projected and perpetuated masochistically upon society." Such statements would presuppose that all criminal behavior is on the same basis—an oversimplification that previously was used in mental disease as well. Later, in discussing murder, the same type of overgeneralization and oversimplification is used. Such statements only confuse rather than clarify the issues.

The chapters dealing with the psychiatrist's role in the court are well written and cover the subject adequately. There is also a chapter on the present and future role of the psychologist as an expert in the court. Treatment aspects of the criminal are described in overoptimistic terms. The role of the psychiatrist in criminal behavior is a difficult one, however, and any book which can bring about some enlightment on this subject is worth while. Certainly every reader of this one should find something of benefit.

Lectures on Experimental Psychiatry. HENRY W. BROSIN, M.D., editor. 361 pages. Cloth. University of Pittsburgh Press. Pittsburgh. 1961. Price $7.50.

The Western Psychiatric Institute and Clinic did its part in the observance of the bi-centennial year of Pittsburgh, Pa. in 1959 by conducting a conference on experimental psychiatry. The lectures presented in this volume, most of them delivered at that conference, cover an extraordinary breadth of field and an extraordinary wealth of material. Notable contributors include Franz Alexander, M.D.; Jack R. Ewalt, M.D.; Roy R. Grinker, M.D.; Lawrence S. Kubie, M.D.; Howard S. Liddell, Ph.D.; and William Malamud, M.D. One of the more unusual contributions is by Warren S. McCulloch, M.D., "Where is Fancy Bred?" It is concerned with "artificial intelligence" and the general problem of design of the brain. McCulloch remarks, "... in building models for the soul or Psyche, it behooves us to employ the pre-ordained harmony of natural objects." The organization of discovery is discussed in a brief and stimulating essay by Francis J. Gerty, M.D. Ewalt's discussion of "The Shape of Research" should also be noted. Altogether, this is a most stimulating work for anybody in the wide field of psychiatry.

Theories in Logic. By WILHELM WINDELBAND. 81 pages. Cloth. Philosophical Library. New York. 1961. Price $2.75.

This essay was originally printed as part of a larger encyclopedia in 1912. The author discusses the philosophical basis for logic, based on the principles of formal logic. With the newer concepts in logic, the book is, therefore, outdated. However, as an example of a classical philosophical approach and of the thinking of one of the outstanding German philosophers, the book is a valuable contribution. The translation is excellent and does not suffer from the usual complicated style of many translations from the German.

Challenge of Psychical Research. (A Primer of Parapsychology) By GARDNER MURPHY. 297 pages, including index. Cloth. Harper. New York. 1961. Price $6.00.

This small volume on parapsychology by one of the eminent psychologists of our day is an enthusiastic collection of source material on such psychical phenomena as telepathy, clairvoyance, precognition, and psychokinesis. Contrary to the climate of disbelief and the relegation to the realm of nonsense to which such phenomena have been subjected by the great body of his fellow-psychologists, they are treated respectfully, thoughtfully, and seriously by Dr. Murphy. Although he admits to a readiness toward accepting such data, he is ever the objective, careful, and incisive thinker.

His purpose here is to present the evidence offered, and to point up their challenges to modern scientific scrutiny. Not aimed at surveying the field, the book is far from exhaustive. Not aimed at convincing or proselytizing, it is mainly a descriptive endeavor, with some astute and sensible comment on both the credibility and the creditability of the events that are described. The final chapter is devoted to an assessment of the problems, procedures, and results of psychical research, and it is done with characteristic efficiency.

Murphy, in making a plea for open-mindedness, intimates that only through a willingness to consider the parapsychological phenomena as sensible will we begin to understand them properly. As in most scientific research, generalizations rest on probabilities, not on absolute proof; the latter is not required of other types of research, it should not be required for psychical research. Also needed are better methods of replicating experiments and a more serviceable conceptual or theoretical framework in which to order these extraordinary events.

When an experimental hypothesis is not rejected as a chance occurrence, one must either accept the experiment as supporting the hypothesis, as is done in other branches of psychology or science, or accept the alternative explanations of fraud or chicanery or coincidence. (Apropos of such concern with explanations, a story by W. Sullivan in the July 2, 1961, *New York*

Times reports on a lively debate in the U.S.S.R. engendered by a French story of telepathy experiments done on the *Nautilus* by the United States Navy. Although the navy denied doing such experiments, the Russians continued their controversy. Similarly, an Associated Press story recently reported rather lightly on the serious endeavors of a psychiatrist, Ian Stevenson, to study reincarnation.)

This book is recommended to the dubious, the curious, and the serious workers in parapsychology.

Free Minds. . . A Venture in the Philosophy of Democracy. By RALPH WALDO NELSON. 291 pages. Cloth. Public Affairs Press. Washington, D.C. 1961. Price $4.50.

This book is an attempt to present the author's views on the philosophy of democracy. He uses the scientific method applied to philosophical thought. Believing that democracy is the highest form of civilized communities, the author presents the development of government from the Greek city-states and the early Judeo-Christian tribal forms. He develops the role of the Roman Catholic Church in the preservation of civilization, but in the retardation of governmental democracy, throughout the Dark Ages. He then turns to the American Revolution and the development of his theme that federalization is the road to successful world integration. He attempts to prove his thesis by the use of Dewey's five points in the development of successful social formation: (1) a felt difficulty; (2) its location and definition; (3) the suggestion of a possible solution; (4) the development by reasoning of the bearings of the suggestion; (5) further observation and experiment leading to the acceptance or rejection of the solution. The final chapters deal with the possible future applications of these principles.

This is a stimulating and provocative presentation of present-day democracy in action.

The Phenomena of Depressions. By ROY R. GRINKER, SR., M.D., et al. 249 pages. Cloth. Hoeber. New York. 1961. Price $6.50.

This book is the result of a research project carried out by the authors and others on a small group of patients to attempt to classify the various forms of depression and to isolate and catalogue the symptoms characteristic of each. The authors drew up large numbers of check lists and symptoms in an attempt to find symptoms, feelings and signs that are characteristic. They used the Q-sort technique for their analytic method and, on the basis of their statistics, found various correlations.

As a research method, this study is of interest. However, it adds no new real knowledge of practical value to the clinical psychiatrist.

Plasma Proteins in Health and Disease. GEORGE T. DIMOPOULLOS, conference editor. 41 authors. 335 pages. Paper. New York Academy of Sciences. New York. 1961. Price $4.50.

The topic of plasma proteins encompasses a broad field of investigation which has been pursued intensively for the past quarter-century and recently more intensively with the improved methods of electrophoresis, immunology and biochemistry. It is apparent from the material included in this monograph that one of the principal problems of the field is coordination and a necessity for acquainting specialists in the area with the work of other specialists with whom they do not ordinarily come in contact. The monograph is divided into five parts which are: Dynamic and Biochemical Properties of Plasma Proteins; Abnormal Components of Plasma in Disease; Immunologic Phenomena and Alterations of Plasma Proteins in Infectious Disease; Genetic, Induced, Nutritional, and Environmental Factors Affecting the Plasma Proteins; and Influence of Nonspecific Physiologic Conditions Affecting the Plasma Proteins.

Abnormal Psychology. By WALTER COVILLE, TIMOTHY W. COSTELLO, and FABIAN ROUKE. 298 pages, including index. Paper. Barnes & Noble. New York. 1960. Price $1.75.

One of the College Outline Series, this text is an excellent undergraduate introduction to the field of mental illness. It takes a broad approach to types and causes, preceeded by a historical account and a review of pertinent personality theory. Diagnostic and therapeutic procedures are also outlined sufficiently to orient the student to the problems and approaches. This reviewer's major criticism would be the general emphasis in the section on mental retardation, and the use of outdated classification systems, including the terms "idiot, imbecile and moron," which are no longer being employed.

Psychology in Teaching Reading. By HENRY P. SMITH and EMERALD V. DECHANT. 470 pages, including index. Cloth. Prentice-Hall. Englewood Cliffs, N. J. 1961. Price $9.00.

This is an excellent text which will surely interest all teachers and will have particular value to those actively involved in teaching reading. The authors have carefully drawn upon a vast amount of psychological and educational data in their presentation of the nature of the learning process. Although learning to read and the problems involved in this particular area are always the focal point, anyone interested in other aspects of educational methods will find this book highly rewarding.

Brotherly Love. By GABRIEL FIELDING. 282 pages. Cloth. Morrow. New York. 1961. Price $3.95.

Fielding presents the third volume of a "grand opus," of which earlier volumes were considered brilliant by some reviewers; this one emphatically disagrees.

The Hobo. The Sociology of the Homeless Man. By NELS ANDERSON. xxix and 296 pages. Paper. Phoenix Books. University of Chicago Press. Chicago. 1961. Price $1.95.

This is a Phoenix paperback edition of Anderson's 1923, original University of Chicago Press edition, which has now become a classic in the field of nomadism. The present edition contains an autobiographical sketch by the author who, born into a migrant family, had himself been a hobo. The book, he explains, was originally written as a graduate student's thesis at the University of Chicago where he had gone to gain an advanced degree in sociology. Anderson's hobo is a different person from Jim Tully's and with good reason—Anderson became a university scholar, and Tully stayed a hobo. Still, the men that both wrote about had much in common. The hobo Anderson wrote about is gone from the American scene. Tully's hobo is the vagrant of today.

In the original work, Anderson tacitly rejects the implication of psychopathology in the hobo. In his introduction to the paperback he does so explicitly. Anderson sees in the mobility of present-day families a continuation of an American tradition of mobility of which the hobo represented one phase.

The original book, which is reproduced here, contains a rich fund of well-organized and informative material about the homeless man. This is one of the important source books with which every psychiatrist should be familiar.

The Psychotherapy Relationship. By W. W. SNYDER, Ph.D., and B. JUNE SNYDER, M.A. 408 pages. Cloth. Macmillan. New York. 1961. Price $7.50.

This book presents an analysis of the relationships that developed between one therapist and 20 clients during the course of psychotherapy. The research is based upon the premise that the relationship between therapist and client is as important in therapy as the various techniques which are employed. To measure this relationship quantitatively the authors developed two scales, a "Clients' Affect Scale and Therapist's Affect Scale." After each interview, the client filled out a 200-item questionnaire reporting his attitude toward therapy and the therapist. The therapist also filled out a questionnaire about his attitudes toward the client, his estimate of the client's feelings toward him, of the client's progress in therapy, and of the client's emotional maturity. Clients were dichotomized into two groups, i.e., "better" and "poorer."

The data revealed a highly significant correlation between scores on the "CAS" and the "TAS." This constitutes a measure of the transference and countertransference and thus of the therapy relationship itself. During the course of therapy, approximately 25 interviews, there was a tendency for transference and countertransference to vary in positive relationship

with each other. Ths is interpreted to be statistical proof of the "Law of Talion," that is in this situation, for every aspect of transference there is a reaction in countertransference.

The authors present a detailed statistical analysis of their findings, as well as numerous verbatim reports of therapy sessions. These illustrative cases include classification of the therapist's responses to statements made by the client and affect scores for both client and therapist.

The authors believe that it is the "reciprocity of various sets of affective attitudes" which constitutes the basic component of therapy. When client and therapist are "properly matched," the chances of developing a positive and effective therapeutic outcome will be increased.

This book should prove especially useful for the student-therapist and for those who employ counseling or psychotherapy in their professional work. It may even serve as impetus for further research in the area of interpersonal relationships, a field of study which is shared by psychiatry, psychology, and sociology.

Psychic. The Story of Peter Hurkos. By PETER HURKOS. 224 pages. Cloth. Bobbs-Merrill. Indianapolis. 1961. Price $3.95.

In June 1943, Peter van der Hurk, a 32-year-old house painter in Holland, fell off a scaffolding. When he regained consciousness, he says he found that the gift of extrasensory perception had been accorded to him. The present book is his own story of his "gift." Now a resident of Milwaukee, he runs the Peter Hurkos Foundation, Inc. and is interested in commissions to find treasures, lost objects, to foretell the future and enable you to distinguish friend and foe. He is now also active in a gold mining operation.

According to Hurkos, his extrasensory perceptions occur as visual flashes of a fragmentary nature. Contacts with objects belonging to persons facilitate the experience. Hurkos gives a layman's account of his participation in various experiments and reports the results which the sponsors included in their reports. He has had some experience with equipment such as the electro-encephalograph, and with hallucinogens. Most of the book consists of a recountal of "positive" results. There is no index by which one could check his known negative experiences, and this first printing is defective, with pied linotype assemblies on pages 204 and 205.

Degrees. By MICHEL BUTOR. 351 pages. Cloth. Simon and Schuster. New York. 1962. Price $5.50.

There is not much story in this revolutionary anti-novel from France about a high school teacher who feels the need to record all that goes on in his geography class. In his compulsive drive to record all of experience, the author favors an atomized approach and is thus unable to deal with the human experience. The book, however, is expertly written and is recommended to those who are concerned more with style than with plot.

Personality: An Experimental Approach. By ROBERT W. LUNDIN. 450 pages, including index. Cloth. Macmillan. New York. 1961. Price $5.75.

This book is a study of personality from the point of view of learning or reinforcement theory. Although the treatment of the subject is "behavioristic" and intended as a text for use of the advanced undergraduate student in psychology, it would amply repay conscientious reading by practising members of the mental health professions. Despite a rather prideful, almost boastful, recurrence of statements pointing up its use of the "experimental approach" and the "scientific method," the book contains much important and solid material on the psychology of personality. It is recommended not only to the serious student, but also to the psychiatrist or clinical psychologist who, in deferring to the demands of practice, may have tended to lose sight of the vital underpinnings of the basic principles of psychology.

Equitable Payment. By ELLIOT JAQUES. 336 pages. Cloth. Wiley. New York. 1961. Price $6.00.

The author of this work in socio-economic theory, employs the term "psychoeconomics" for those features which give it its individual character. Persons are unconsciously aware (he says, in essence) of what they can do, of what value their work has and of what they should be paid for it. Sound adjustment requires the balance of these factors. A similar relationship with regard to outlay exists (the individual's expenditures are properly adjusted when they yield a consumption consistent with "dynamic psychological equilibrium"). An optimum level of payment exists when it provides "a person whose capacity is just up to that work with an income which matches his capacity for discriminating expenditure and his level of satisfaction consumption."

The author is apparently a labor-management relations analyst employed by a British company called Glacier Metal (not included among the industrials listed by the *London Financial Times*) and takes some pains to prevent criticism of himself as pro-management.

If one accepts Jaques' postulates without examining closely into the frame of reference in which his value judgments are cast, there is little opportunity to argue with him. The simplest method of arriving at equitable payment under this system would be piecework, but Jaques admits that pieceworkers in factories are likely to be limited by shortcomings in management and that the system is not popular with either labor or management. Furthermore, it must be obvious that the real limitation in piecework is not the worker but the methods which are placed at his disposal.

Jaques has been confronted at every turn by implicit value judgments which compelled him to develop a somewhat arbitrary approach, in which his theory becomes the conditioning factor and the individual circum-

stances of his industry are the fixed points. What is good work? When Jaques tells us, it is good if it measures up to the quality the customer expects, one realizes that his theory is cast in too narrow a frame of reference to have a very wide application. Jaques also has a hard time with the differing needs of individuals and one is amused by a footnote he places at the bottom of an early page of the book to deal with the problem of equal pay for persons who have different obligations. Says he, "I have little doubt that a social analysis would reveal the existence of unconscious social norms about the value to a person of having a family, and how much national taxation and social benefits ought to influence the net incomes of single and married employed persons."

The psychiatrist will be interested by the way in which Jaques has learned to evaluate the emotional reactions of his associates, but Jaques seems to be too close to his environment to have ever had it occur to him to doubt that the estimate a worker places upon what his labor is worth has a stable relationship to anything immutable in the economic world.

Studies in Behavior Pathology. By THEODORE R. SARBIN. 341 pages, including index. Paper. Holt, Rinehart and Winston. New York. 1961. Price $4.00.

Written as a "supplementary textbook" for undergraduate psychology courses that may be subsumed under the general rubric of behavior pathology, this volume is a collection of 39 papers on research into psychopathology. Carefully selected on the basis of firm and explicitly stated criteria, these papers deal with definition; etiology; theories of learning-disorder effecting disturbed behavior; schizophrenia; mood disorders; defects of socialization; physiological and cerebral disturbances; and prognosis.

Despite the stated purpose to reach students, the volume makes rewarding reading for even the well-established professional, unless the articles were previously read in their original contexts. A large number of them were selected from such psychological journals as the *Journal of Consulting Psychology* and the *Journal of Abnormal and Social Psychology*. They also came from psychiatric, neurological and sociological journals. This volume is neither elementary nor trivial.

Principles and Procedures of Statistics. By ROBERT G. D. STEEL and JAMES H. TORRIE. 481 pages, including index. Cloth. McGraw-Hill. New York. 1960. Price $10.50.

Graduate students with a minimal amount of mathematics in their backgrounds will find this text helpful in the use of basic statistical concepts and methods. It is intended primarily for students and research workers in the fields of agriculture and biology, and should be used in conjunction with course work on a graduate level.

The Darkening Glass. By JOHN D. ROSENBERG. 274 pages. Cloth. Columbia University Press. New York. 1961. Price $5.00.

The author has written a penetrating critique of Ruskin's books and has attempted to relate his writings to social, economic and political problems of the nineteenth century. He minimizes, however, the importance of Ruskin's emotional development and of his emotional problems and their relationship to his writings. He mentions that Ruskin was brought up by a strict Calvinistic mother and with Victorian ideas of the righteous power of money; he notes his impotence, his inability to consummate his marriage, his seeking of companionship with immature girls, his feelings of guilt, his disposal of his fortune. All of these contributed to his writings and to his final psychotic breakdown. The author mentions a manic delirium and depression, and writings that were sometimes irrelevant and rambling, and at other times self-accusatory. With the little information given, it would seem that Ruskin was suffering from a manic-depressive psychosis of an almost circular type during the latter part of his life, swinging from depression to mania at frequent intervals. If the author had attempted to relate Ruskin's mental aberrations to his writings a much clearer understanding of the man would have resulted.

However, this is an excellent critique, and the author has written an eloquent testimonial, which covers most of Ruskin's writings and gives him his place in the nineteenth century.

Neurosis and Psychosis. By BEULAH C. BOSSELMAN, M.D. 181 pages. Cloth. Thomas. Springfield, Ill. 1961. Price $6.00.

The book reviewed here is the second edition and revised third printing of a work which can be considered as containing the basic information relative to the neuroses and the psychoses that is needed in teaching medical students. It is based upon the series of lectures given each year since 1940 to medical and postgraduate students at the University of Illinois College of Medicine.

Starting with the explanation and nature of symptoms found in mental illnesses, Dr. Bosselman proceeds to describe and illustrate each neurosis or psychosis. She conveys psychoanalytic concepts in such a way that students can understand.

Dr. Bosselman then proceeds to tell the reader how the psyche and the soma are interrelated—psychosomatic medicine—and finally tells how psychiatric knowledge should be used in the general practice of medicine.

At the end of each chapter there is a list of suggested supplementary reading which should be helpful to the student or to the doctor who is seeking knowledge about basic psychiatry.

Thought and Language. By L. S. VYGOTSKY. XXI and 168 pages. Cloth. M.I.T. Press and Wiley. Cambridge, Mass. and New York. 1962. Price $4.95.

Very little is known outside Russia about this psychologist who died in 1934 at the age of 38. The present book is a translation of the posthumous Russian original published in the year of his death. Interest in many of the problems discussed by Vygotsky has subsequently taken a different turn from that which was being pursued at that time; and of course, methods of investigation have also changed. Evidently the renewal of interest in this volume stems from the fact that it was suppressed and only recently became available again.

The book is accompanied by a pamphlet by Piaget, which deals with the latter's evaluation of that part of the book which touches upon Piaget's work in the twenties. Much of Vygotsky's concern is, therefore, with the problem of speech development in children and in particular with the issue of egocentrism in that connection. His quarrel with Piaget stems, not from disagreement with the idea that the speech of the child is egocentric, but from disagreement with the latter's concern with infantile intellectual egocentrism. Piaget's decision makes it plain that the questions at issue are susceptible to reconciliation by redefinition.

Most readers of this journal will find material of interest in this book, not perhaps because of the matters mentioned, but because of Vygotsky's ability to express himself about issues such as inner speech which are of interest in understanding schizophrenia. The book has a functional index.

The Method in Madness. A Unitary Neuro-Physiological Theory of Neurosis and Psychosis. By ZDNEK J. VACLAVIK. xii and 344 pages. Cloth. Zdenek J. Vaclavik (Publisher). 1961. Price $8.50.

Vaclavik is both the author and publisher of this theoretical effort to present "a new comprehensive theory of the neuroses and of the so-called functional psychoses, involving the various forms of schizophrenia, depression and mania. It also deals with the mechanisms of psychosomatic disorders."

He believes, "Many common but hitherto unexplainable clinical and psychopathological phenomena became amenable to rational explanation for the first time. Also the role of heredity in mental illness takes on a concrete meaning, and can now be defined in physiological terms. In regard to the formation of human conscience, the respective importance of biological and environmental factors can, at last, be more objectively assessed."

This reviewer does not agree with him. He thinks that Vaclavik has undertaken a task for which he is inadequately prepared and has attacked it by an analogical method which does not inspire conviction.

Oligophrenia. Mental Deficiency in Children. By M. S. PEVZNER. xiii and 406 pages. Cloth. Consultants Bureau. New York. 1961. Price $15.00.

This book was originally published in Moscow in 1959. The author is senior psychiatrist at the Institute of Defectology which is associated with the University of Moscow. Tizard of Maudsley Hospital, who has been instrumental in bringing this book forward, does not make clear whether Dr. Pevzner's approach to her subject is representative of work in this field generally in Russia. Since it is a highly individual and theoretical presentation, one would think not. On the other hand there is no indication in this volume that the important advances in Scandinavia and other parts of the Western World, in the fields of genetics and biochemistry, have exerted any influence on the understanding of mental retardation in Russia. The absence of an index makes it difficult to check back through the book for comparative purposes.

In Pevzner's sense, oligophrenia is mental defect due to organic disease, but the author is not deeply concerned with the nature of that defect. Indeed, one is struck by two characteristics of Pevzner's writing which, if encountered in a Western writer, would antagonize the reader. These are a tendency to beg the question and the frequent employment of *ad hoc propter hoc* reasoning. What Pevzner really seems to be interested in accomplishing is the development of a Pavlovian-oriented theory, with a view toward obtaining maximum rehabilitative results. While this theory is brought into contact with the scientific background of the organic causation of mental defect, Pevzner's concern with such matters is certainly not of an obsessive nature.

The Unconscious. By J. P. CHAPLIN. 194 pages including index. Paper. Ballantine Books. New York. 1960. Price 50 cents.

Chaplin presents a generally accepted view of the unconscious, mostly Freudian, with careful simplification for popular reading. His chapters cover such matters as dreams, the psychoses and neuroses, hypnosis, extrasensory perception, religious healings and manifestations of the unconscious in everyday life.

This is an excellent little book. Some of the material which is outside the generally recognized fields of psychiatry and psychology should be not only of interest but of practical value to the physician. There is a note, for example, that Christian Science, contrary to early practice and to present general belief, allows the Christian Science practitioner to refer a patient to a doctor when Christian Science treatment fails to bring healing. A personal note from the author to this reviewer bases this statement on the 89th edition of the church's manual and on discussion with a practitioner who so refers patients. The usefulness of this sort of thing is obvious.

LEONARD C. LANG, M.D.

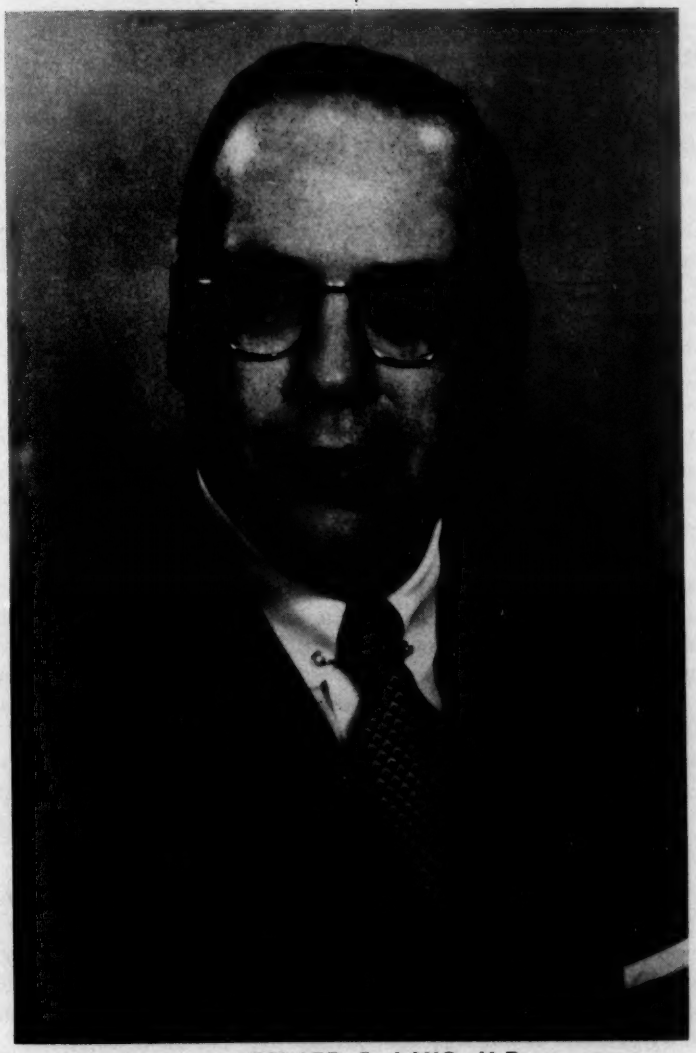
Leonard C. Lang, M.D., assistant director (administrative) at Buffalo State Hospital since 1953, became assistant commissioner in charge of community services of the New York State Department of Mental Hygiene on December 14, 1961, by appointment of Commissioner Paul H. Hoch, M.D.

Born in New York City, Dr. Lang is a graduate of Colgate in 1931, and of Albany Medical College in 1935. After interning at St. Peter's Hospital, Albany, he entered New York state service at Buffalo State Hospital in 1936. He had been assistant director there 12 years in all, the first four in charge of clinical services, when he was appointed to the Albany post.

In Albany, Dr. Lang is in charge of co-ordinating the department's community mental health activities, which include state aid for developing local psychiatric services, social service, aftercare services and the department's child guidance clinics. Dr. Lang served in the army medical corps for five years during World War II, taking part in five campaigns on the European continent from the Normandy landings to V-E Day. He recently retired as a colonel from the reserve corps after having held a commission for 24 years.

Dr. Lang has done postgraduate work at Columbia, Syracuse, the Psychiatric Institute, the Neurological Institute and Montefiore Hospital. He is certified in psychiatry by the American Board of Psychiatry and Neurology, and holds the certificate as mental hospital administrator of the American Psychiatric Association. He is a fellow of the American Psychiatric Association and a member of numerous other professional organizations. He is a former president of the Buffalo Neuro-psychiatric Association. He has been on the faculty of the University of Buffalo Medical School since 1947.

Dr. Lang has been active in community and service affairs ranging from the American Legion and Veterans of Foreign Wars to Scouting, parent-teacher organizations and the Buffalo Kiwanis Club. He is an enthusiastic golfer, as is his wife, the former Genevieve Meagher of East Bloomfield, N. Y. Their son, Thomas, is a junior at Colgate, with plans to enter the foreign service.



LEONARD C. LANG, M.D.

CONTRIBUTORS TO THIS ISSUE

JOHN H. CUMMING, M.D. Dr. Cumming is director of the Mental Health Research Unit of the New York State Department of Mental Hygiene, located in Syracuse, N. Y. He graduated from the University of Toronto in 1949 and spent two years as a special auditor in the Department of Social Relations at Harvard University. He holds the certificate in psychiatry of the Royal College of Physicians and Surgeons of Canada. He is clinical assistant professor at the Upstate Medical Center and a research consultant to the Department of Psychiatry at Montefiore Hospital in New York City, Fountain House in New York City, and Marcy State Hospital. He is especially interested in social psychiatry and has published a number of papers and contributed to several books in this area.

NEWTON BIGELOW, M.D. Dr. Bigelow is director of Marcy (N.Y.) State Hospital and editor of THE PSYCHIATRIC QUARTERLY and THE PSYCHIATRIC QUARTERLY SUPPLEMENT; he has served as commissioner of mental hygiene of New York State. Born in Ontario in 1904, he is a graduate of the medical school of the University of Western Ontario. He joined the New York State hospital system after a general internship, and has remained with the New York state hospitals ever since. He has been director of Marcy since 1945, with a leave of absence from this position from 1950 through 1954 when he was commissioner of mental hygiene. He is a diplomate in both psychiatry and neurology of the American Board of Psychiatry and Neurology and is author or co-author of a number of scientific articles. He has been editor of THE QUARTERLY and SUPPLEMENT since October 1947. He is clinical professor of psychiatry at the Upstate Medical Center of the State University of New York, Syracuse.

A. L. HALPERN, M.D. Dr. Halpern is commissioner of mental health of Onondaga County, New York. When the paper in this issue of THE SUPPLEMENT, of which he is co-author, was written he was associate research scientist (psychiatry) of the Mental Health Research Unit of the New York State Department of Mental Hygiene. A graduate of the University of Toronto in 1952, Dr. Halpern received psychiatric training at Warren (Pa.) State Hospital where he had served as senior psychiatrist before joining the Mental Health Research Unit. He is certified in psychiatry by the American Board of Psychiatry and Neurology and is clinical instructor at the Upstate Medical Center of the State University of New York, Syracuse.

CAROLYN R. CALTHROP, B.A. Mrs. Calthrop received her bachelor's degree from Syracuse University and completed two years of graduate study at the Syracuse University School of Social Work. She has been doing psychiatric social work for more than 12 years and had previously had experience in agencies including public assistance, child welfare, disaster work, army and navy emergency relief and federal housing. She was psychiatric social worker for more than two years in an adult out-patient mental hygiene clinic sponsored as a pilot project by the Red Cross to demonstrate community needs. She was with a New York State child guidance clinic for eight years and since the spring of 1960 has been a senior supervising psychiatric social worker at Marcy (N.Y.) State Hospital. She served at Marcy first in the Crane Hill School Residential Treatment Center for children and later in the Marcy Adult Social Area office of Onondaga County.

MARY CHARLOTTE CRILL, R.N. Mrs. Crill a graduate of the Marcy State Hospital School of Nursing and of the University of Rochester is the psychiatric nursing instructor at Marcy State Hospital. She is a member of the American Nurses Association and the National League for Nursing.

LEONA WISE JONES, Ph.D. Dr. Jones graduated from Ohio State University in 1919, where she received her M.A. in 1933. In 1944 she received her Ph.D. in psychology and personnel administration from Northwestern University. Since 1936, she has been associate professor of education at Illinois Wesleyan University, professor of personnel administration at Ohio University, and professor of personnel psychology at Denison University. She has served as dean of women at all of these institutions, as well as at Ohio Wesleyan University.

Dr. Jones was sent to Japan in 1951-1952 by the Department of the Army as a specialist in student personnel services. For several months in 1959, she taught educational psychology and educational tests and measurements at McCoy College of The Johns Hopkins University.

Since 1959 she has been research psychologist for the long-term study of the precursors of hypertension and coronary artery disease, which is in progress at the Johns Hopkins University School of Medicine.

She is a member of the American College Personnel Association, of the American Personnel and Guidance Association and other professional organizations; of Psi Chi and Phi Kappa Phi; of the American Board on Counseling Services, Inc., and is a contributor to educational journals.

CAROLINE BEDELL THOMAS, M.D. Dr. Thomas was graduated from Smith College in 1925 and from the Johns Hopkins University School of Medicine in 1930. She served three years as house officer and assistant resident in medicine in the Johns Hopkins Hospital, then, as National Research Council fellow in medicine, studied the circulation of the brain and the carotid sinus reflex at Harvard and Johns Hopkins.

Since 1935 she has been a member of the Department of Medicine at Johns Hopkins, where she is now associate professor. From 1935-1945, her research included studies on experimental and clinical hypertension and on the prevention of rheumatic fever. From 1943 to 1945, she served as civilian consultant to the Surgeon General of the Army in regard to the prevention of rheumatic fever. Since 1946, she has been director of a long-term study now in progress concerning the precursors of hypertension and coronary artery disease, a study from which the present paper stems. She has published over 60 articles on a variety of medical subjects.

She is a diplomate of the Board of Internal Medicine and a member of Phi Beta Kappa, Alpha Omega Alpha, and Sigma Xi as well as a number of medical societies, including the American College of Physicians, the Association of American Physicians, and the Council for High Blood Pressure Research of the American Heart Association. She received an honorary doctor of science degree from Smith College in 1955, the James D. Bruce Memorial Award in Preventive Medicine from the American College of Physicians in 1957 and the Elizabeth Blackwell Citation in 1958, all for pioneer work in the prevention of rheumatic fever.

JOHN J. HORWITZ, M.S.W. Mr. Horwitz is responsible for the "Dynamics of Social Process" course at the University of Toronto School of Social Work and also teaches several other courses in human growth and behavior. He received his social work degree from the New York School of Social Work, Columbia University, in 1946, having spent a period in field instruction at the New York State Psychiatric Institute in 1942. He is at present enrolled in the doctoral curriculum in sociology at Columbia. His professional experience includes service as consultant on child welfare and juvenile delinquency to the mayor of the City of New York and as research consultant to the New York City Community Mental Health Board's study of psychiatric clinics in the city's courts. From 1955 to 1958, he was associate director of the curriculum study of the Council on Social Work Education.

PAUL COMSTOCK AGNEW, M.D. Dr. Agnew is in psychiatric practice in Chicago where he is associate professor of the department of psychiatry at Northwestern University Medical School, is a candidate in the

Chicago Institute for Psychoanalysis, and is a clinical associate at the Psychiatric and Psychosomatic Institute of Michael Reese Hospital. Born in 1923 in New York State, he is a graduate of Williams College and received his medical degree at McGill University Medical School in 1951. During World War II he held a commission in the army signal corps, serving in the Mediterranean theater of operations. After his medical school graduation, he served an internship in an army hospital, then served residencies in psychiatry at Strong Memorial Hospital, Rochester, N. Y., where he was chief resident in 1955 and 1956. He has been in Chicago since 1956. He was chief of psychiatric service at the Veterans Administration Research Hospital in Chicago from 1958 to 1961. He is author of a number of scientific publications.

BARRY BRICKLIN, Ph.D. Dr. Bricklin is an instructor in psychology in the department of psychiatry at the Jefferson Medical College of Philadelphia. He received his Ph.D. from Temple University, at which place he also met his wife, Patricia, who teaches there in the Department of Psychology. Dr. Bricklin is secretary-treasurer of the Philadelphia Society for Projective Techniques (his wife is president of this same society). He is also editor of the Newsletter of the Philadelphia Society of Clinical Psychologists, and is a research consultant for the Walter Reed Army Hospital Research Center. His published investigations concern prognosis in schizophrenia, clinical use of a measure of affiliative need, and the use of the Rorschach in intercultural study. He is co-author of a book now in press concerning the prediction of overt aggressive behavior by means of a new projective test (the Hand Test). The Bricklins have a young son, Brian, who, they hope, will also be a psychologist.

SOPHIE B. GOTTLIEB, Ed.D. Dr. Gottlieb received her B.S. degree from Barnard College in 1920, then attended Teachers College, Columbia University, and received her M.A. degree in child development and parent education in 1935, her professional diploma in psychological counseling in 1945, and her Ed.D. degree in marriage and family life in 1960. She had received additional training at the New School for Social Research, the New York School of Social Work, the New York Psychoanalytic Institute and the Postgraduate Center for Psychotherapy. From 1932 through 1935, she conducted a family consultation service under the auspices of the Board of Education, New York City.

Dr. Gottlieb is a certified psychologist, group psychotherapist and marriage counselor. She has done considerable research on marriage compatibility and has published a number of articles concerning married

couples in group psychotherapy. She is a member of the American Psychological Association, the American Association of Marriage Counselors, the American Group Psychotherapy Association, the Society for Projective Techniques, the New York Academy of Science and other professional societies. She is also a member of Phi Beta Kappa, Pi Lambda Theta and Kappa Delta Pi. Dr. Gottlieb is listed in *Who's Who of American Women,* Volume 1, and *Who's Who in the East,* Volume 8.

She is married to Dr. Bernhardt S. Gottlieb, who is a psychiatrist and is the author of *Understanding Your Adolescent, What a Boy Should Know About Sex* and *What a Girl Should Know About Sex.* They have four children, all married, and nine grandchildren.

JAMES J. LAWTON, JR., M.D., Dr. Lawton is director of child psychiatry at Minneapolis General Hospital and assistant professor of child psychiatry and pediatrics at the University of Minnesota Medical School. He is a graduate of the Long Island College of Medicine, served a residency in internal medicine and was a cardiologist before beginning psychiatric training in Brooklyn (N.Y.) State Hospital. He was senior psychiatrist and supervising psychiatrist there from 1949 to 1955. He was trained in child psychiatry at the Institute of the Pennsylvania Hospital and is certified in psychiatry and qualified in the subspecialty of child psychiatry. He has been a lecturer at the American Institute of Psychoanalysis, a visiting lecturer at Teachers College, Columbia University and a clinical assistant professor at the Downstate Medical Center, State University of New York.

FRANK J. SISKO, M.S.S. Mr. Sisko is a senior psychiatric social worker at the Child Study Center, Inc. of Philadelphia. He is a graduate of the Fordham University School of Social Service and a charter member of the National Association of Social Workers. Mr. Sisko was formerly assistant instructor, Department of Pediatrics of the State University of New York, College of Medicine in Brooklyn. Previous to that he was employed as a psychiatric social worker by the City of New York Department of Hospitals in the psychiatric division of Kings County Hospital in Brooklyn.

EUGENE B. GALLAGHER, Ph.D. Dr. Gallagher is research co-ordinator at the Boston Evening Clinic and a lecturer at Boston University. A graduate of Lehigh University, he received his Ph.D. from Harvard in 1958. He was a research fellow at the Harvard Medical School from 1955 to 1958.

STANLEY S. KANTER, M.D. Dr. Kanter is psychiatrist-in-chief of the Boston Evening Clinic and assistant director of the division of legal medicine of the Massachusetts Department of Correction. He is an instructor in psychiatry at the Harvard Medical School and a clinical instructor in psychiatry at the Tufts Medical School. He received his bachelor's and master's degrees from Harvard, and his M.D. from Washington University in 1943.

JAMES A. BRUSSEL, M.D. Dr. Brussel is assistant commissioner of the New York State Department of Mental Hygiene and director of aftercare clinics. He is co-ordinator for the New York State Interstate Compact on Mental Health, and is considered "father" of the compact which is now in effect in 22 states. Dr. Brussel is a diplomate in both psychiatry and neurology of the American Board of Psychiatry and Neurology and is co-author of two medical textbooks, as well as of numerous scientific papers on psychiatry and neurology. He was a pioneer in the introduction of the Rorschach method into the armed forces and is co-author of *A Rorschach Training Manual,* published by the Department of Mental Hygiene. He is the author of the just-published *Layman's Guide to Psychiatry* and has written both poetry and fiction. His novel, *Just Murder, Darling,* which appeared in 1959, is to be published in paperback editions in the United States and on the European continent. Dr. Brussel is a graduate of both the college and medical school of the University of Pennsylvania. He is a veteran of World War II and of the Korean War, serving as head of neuropsychiatric services. He is a lecturer at Yeshiva University to graduate students of psychology, and is a fellow or member of numerous professional associations.

NEWS NOTES

N. Y. ALCOHOLISM PROGRAM INAUGURATED

An extensive state project for research, prevention and treatment in the field of alcoholism was inaugurated during 1961 under the auspices of the New York State Department of Mental Hygiene. A new Division of Alcoholism has been set up in the department, with Raymond G. McCarthy, associated with the Yale University Center of Alcohol Studies since 1944, as its head. Mr. McCarthy is serving under Deputy Commissioner Henry Brill, M.D., in charge of research and medical services.

When the setting up of the new division was announced in June, Governor Nelson A. Rockefeller established an advisory council to act with the commissioner of mental hygiene and help co-ordinate the new division with other state agencies and departments, as well as with voluntary organizations in the field. The personnel of the 12-member council was announced in December.

Dr. John L. Norris of Rochester, specialist in industrial diseases and public health work, who has long been interested in the medical problems of alcoholism, was named chairman. The other 11 members include three psychiatrists, one general practitioner and surgeon, two attorneys, and two clergymen. One of the three nonprofessional members is president of the National Council on Alcoholism, and the other two have been active in mental health work or alcoholism prevention.

Two new units for treatment and rehabilitation are to be set up in department hospitals, February 1, 1962, a 20-bed in-patient unit at Rochester State Hospital and a 75-bed in-patient unit at Central Islip State Hospital, both intended to be pilot projects to demonstrate the operation of local, comprehensive treatment programs.

LUTHER W. WOODWARD, Ph.D., DIES AT 64

Luther W. Woodward, Ph.D., a senior community mental health representative for the New York State Department of Mental Hygiene since 1954, died in New York City on November 8, 1961 following a heart attack on a subway train in Brooklyn. Dr. Woodward was editor of the *Journal of Psychiatric Social Work*. He had been a Lutheran minister before becoming a social worker.

Born in Pennsylvania, he was a graduate of Gettysburg College. He attended the New York School of Social Work and received his Ph.D. from Columbia University. He had served as president of the American Orthopsychiatric Association and was a member of the Joint Commission on Mental Illness and Health.

Before coming to the New York State Department of Mental Hygiene, Dr. Woodward had been co-ordinator of community mental health services for the mental health commission. He had previously been a field consultant for the National Committee for Mental Hygiene and had served for a number of years as a psychiatric social worker for the bureau of child guidance of the New York City board of education.

Besides a large number of scientific articles, Dr. Woodward was co-author of *The Church and Mental Health, Vocational Rehabilitation of Psychiatric Patients, Better Ways of Growing Up, Mental Health in Modern Society,* and *Jobs and the Man.*

DR. PERKINS TAKES CITY MENTAL HEALTH POST

Marvin E. Perkins, M.D., was sworn in as New York City's first commissioner of mental health services on August 31, 1961. He had been director of the city's Community Mental Health Services and chief executive officer of the New York City Community Mental Health Board. He continues to hold the latter position. Dr. Perkins was formerly chief of the bureau of mental health of the Department of Public Health of the District of Columbia. He is a graduate of Harvard Medical School and holds an M.P.H. degree from the Johns Hopkins School of Hygiene and Public Health. He is married and has six children.

MENTAL HEALTH GROUPS TO MERGE

The National Organization for Mentally Ill Children will merge with the National Association for Mental Health when court approval of the consolidation is obtained. The memberships of the two groups approved consolidation in January 1961.

NEW CHILD STUDY PAMPHLET IS OUT

The Child Study Association has announced the publication of a new pamphlet, "When Children Need Special Help with Emotional Problems." It is intended to help people recognize danger signals and symptoms of severe conflicts in time to obtain treatment before serious trouble develops. The booklet, of 29 pages, lists danger signals, and notes where and from whom help can be obtained. Copies of the pamphlet are available for 40 cents each on application to the Child Study Association of America, Inc., 9 East 89th Street, New York 28, New York.

MARY C. JARRETT IS DEAD AT 85

Miss Mary C. Jarrett, 85, a pioneer in psychiatric social work and in the study of chronic illness, died at University Hospital, New York City, on October 4, 1961. Miss Jarrett, a graduate of Goucher College, organized

the social service department at the Boston Children's Aid Society and the Boston Psychopathic Hospital and was its head from 1913 to 1919. She was widely known as "the mother" of psychiatric social work. For the last 30 years she had devoted herself to the problems of the chronically ill and to the development of community programs to aid them. She had retired several years before her death but had continued to act as a consultant. She was the organizer in 1920 of the Psychiatric Social Workers Group, now the psychiatric section of the National Association of Social Workers.

DR. RODGERS RETIRES AFTER ALMOST 42 YEARS

Arthur G. Rodgers, Jr., M.D., director of Syracuse (N.Y.) State School, has announced his retirement on January 1, 1962 after almost 42 years of state service. Dr. Rodgers has been head of Syracuse State School since 1957. A graduate of Albany Medical College, he entered state service at Willard State Hospital in 1916 and transferred to Hudson River State Hospital a year later. He served in the army medical corps in World War I, then was in private practice and on the staffs of two Veterans Administration hospitals before returning to state service at Hudson River State Hospital. He had been director of Binghamtom State Hospital for four years before he took the Syracuse State School position. He will remain in Syracuse in private practice.

"FAMILY BREAKDOWN" STUDY LAUNCHED

The Family Service Association of America has devoted a special edition of its official journal, *Family Service Headlights*, to the problems of "family breakdown." The special edition was distributed at the association's fiftieth anniversary conference opening in New York City, November 12, 1961.

ERRATUM

SERPENT BIBLIOGRAPHY IS IN PART 2, 1960 SUPPLEMENT

The bibliography for the paper, "Serpent Imagery and Symbolism in the Major English Romantic Poets: Blake, Wordsworth, Coleridge, Byron, Shelley, Keats," by Lura N. Pedrini, Ph.D., and Duilio T. Pedrini, Ph.D. (PSYCHIAT. QUART. SUPPL., 34: 189-244, Part 2, 1960, and 35: 36-99, Part 1, 1961) appeared following the first part of the article in Part 2 of the 1960 SUPPLEMENT. It was intended to be repeated following the second part of the paper in Part 1 of the 1961 SUPPLEMENT, but was omitted inadvertently. Readers are referred to the first half of the serpent article in Part 2 of the 1960 SUPPLEMENT for complete publication data on works referred to in the footnotes.

INDEX TO VOLUME 35

BOOK REVIEWS

THE PSYCHIATRIC QUARTERLY SUPPLEMENT

Vol. 35 1961 Part 2

TABLE OF CONTENTS